
From: Shulkin, David J., MD </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b)(6)>
To: (b)(6) (b)(6) S. (VACO) </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b)(6)>
Cc:
Bcc:
Subject: FW: LPMHC's in the VA
Date: Wed Feb 22 2017 18:05:33 CST
Attachments: Commission-on-Care_Final-Report_063016_FOR-WEB.pdf
LCPC Questions.docx
Letter to Shulkin.docx
RAND_RR806.pdf

Who might be able to look at this?

Sent with Good (www.good.com)

-----Original Message-----

From: (b)(6), (b)(6) L.
Sent: Wednesday, February 22, 2017 03:19 PM Eastern Standard Time
To: Shulkin, David J., MD
Subject: LPMHC's in the VA

Good afternoon Dr. Shulkin,

I watched your confirmation and the Town Hall this afternoon. I hope that you will read my letter and help get the answers I would like to have regarding the use of Licensed Professional Mental Health Counselors and Licensed Marriage and Family Therapists in the VA. The letter and the questions documents pertain to my concerns. The RAND report and Commission on Care are supplemental evidence to support my argument. Thank you for your consideration.

Regards,

(b)(6) L. (b)(6) M.S., L.C.P.C.

Licensed Professional Mental Health Counselor

Substance Abuse Rehabilitation Program

VA Illiana Health Care System

1900 East Main Street Building 103/Ward 2

Danville, IL 61832

(b)(6)

Office (b)(6)

Fax: (217) 554-4815

“Genius is 1% inspiration and 99% perspiration” –Thomas Edison

Owner: Shulkin, David J., MD </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: Commission-on-Care_Final-Report_063016_FOR-WEB.pdf
Last Modified: Wed Feb 22 18:05:33 CST 2017

Commission on Care

Final Report



COMMISSION ON CARE

June 30, 2016

COMMISSION ON CARE

Final Report of the Commission on Care

June 30, 2016

Commission on Care
1575 I Street, NW
Washington, DC 20005



commissiononcare.sites.usa.gov

COMMISSION ON CARE

1575 I Street, NW ▪ Washington, DC 20005

June 30, 2016

We are honored to submit to the President, through the Secretary of Veterans Affairs, in accordance with the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), the enclosed recommendations for transforming veterans' health care. We believe these recommendations are essential to ensure that our nation's veterans receive the health care they need and deserve, both now and in the future.

We worked with an absolute commitment to putting veterans at the heart of our deliberations, and believe our recommendations will create an integrated, community-based health care system for veterans that will be sustainable for the long term. During the term of the Commission on Care, we evaluated the 4,000-page *Independent Assessment Report*; held public meetings; listened to a broad range of stakeholders, including veterans and leaders of veterans service organizations; made site visits to Veterans Health Administration (VHA) facilities; and exchanged ideas with individual veterans, VA and VHA leaders, VHA employees and health care providers, members of Congress, economists, and health care experts.

Overall, the Commissioners agree with the findings of the *Independent Assessment Report*, which are consistent with the expansive body of other evidence the Commissioners have reviewed. This evidence shows that although care delivered by VA is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes. The Commissioners also agree that America's veterans deserve much better, that many profound deficiencies in VHA operations require urgent reform, and that America's veterans deserve a better organized, high-performing health care system.

The most public and glaring deficiency was access problems. Congress attempted to solve this problem through a provision in VACAA that directed VHA to implement a temporary program allowing for greater choice. The Commission finds, however, that the design and execution of the *Choice Program* are flawed. In its place, we offer specific recommendations for standing up integrated veteran-centric, community-based delivery networks that will optimize the balance of access, quality, and cost-effectiveness.

The Commission also finds that the long-term viability of VHA care is threatened by problems with staffing, facilities, capital needs, information systems, health care disparities and procurement. Fixing these problems requires deliberate, concurrent, and sequential actions. It also requires fundamental changes in governance and leadership of VHA to guide the organization during the next two decades through the rapid changes coming in demographics, technology, and in the structure of the overall U.S. health care system.

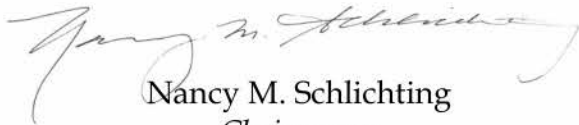
VHA has many excellent clinical programs, as well as research and educational programs, that provide a firm foundation on which to build. As the transformation process takes place, VHA must ensure that the current quality of care is not compromised, and that all care is on a trajectory of improvement. VHA has begun to make some of the most urgently needed changes outlined in the *Independent Assessment Report*, and we support this important work.

Implementing the recommendations in this report will greatly enhance VHA's ongoing reform efforts by providing both a systems-oriented framework and vitally needed changes in organizational structure. Foundational among these changes is forming a governing board to set long-term strategy and oversee the implementation of the transformation process, and building a strong, competency-based leadership system.

The remaining recommendations work in harmony to ensure veterans receive timely access to care, have options for where and how they receive care, are cared for in an environment that embraces diversity and inclusion, and are supported in making informed decisions about their own health and well-being. These recommendations are

not small-scale fixes to finite problems. Instead, they constitute a bold transformation of a complex system that will take years to fully realize, but that our country must undertake to provide our veterans with the high-quality health care they richly deserve.

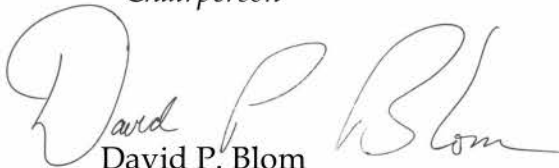
Respectfully Submitted,




Nancy M. Schlichting
Chairperson



Delos M. Cosgrove, MD
Vice Chairperson



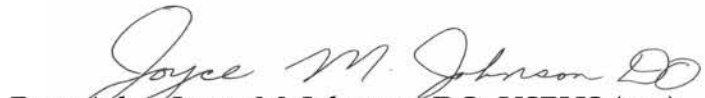
David P. Blom
Commissioner



David W. Gorman
Commissioner



The Hon. Thomas E. Harvey, Esq.
Commissioner



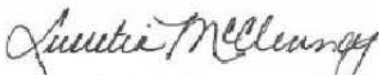
Rear Adm. Joyce M. Johnson, DO, USPHS (ret.)
Commissioner



The Hon. Ikram U. Khan, MD
Commissioner



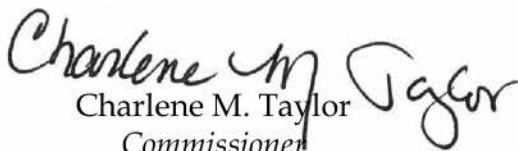
Phillip J. Longman
Commissioner



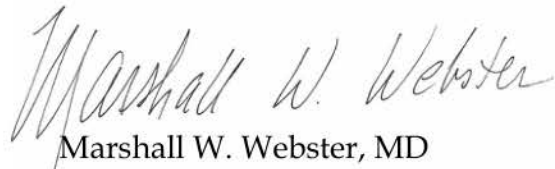
Col. Lucretia M. McClenney, USA (ret.)
Commissioner



Lt. Gen. Martin R. Steele, USMC (ret.)
Commissioner



Charlene M. Taylor
Commissioner



Marshall W. Webster, MD
Commissioner

TABLE OF CONTENTS

TABLE OF CONTENTS.....	VII
LIST OF FIGURES	X
LIST OF TABLES	XI
EXECUTIVE SUMMARY	1
INTRODUCTION	21
COMMISSION RECOMMENDATIONS	23
Redesigning the Veterans' Health Care Delivery System.....	23
The VHA Care System	23
<i>Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.</i>	<i>23</i>
Clinical Operations	37
<i>Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.</i>	<i>37</i>
<i>Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-supported programs.</i>	<i>40</i>
<i>Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.....</i>	<i>43</i>
Health Care Equity	47
<i>Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.....</i>	<i>47</i>
Facility and Capital Assets	55
<i>Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.</i>	<i>55</i>
Information Technology	66
<i>Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.</i>	<i>66</i>

COMMISSION ON CARE FINAL REPORT

Supply Chain.....	81
<i>Recommendation #8: Transform the management of the supply chain in VHA.</i>	<i>81</i>
Governance, Leadership, and Workforce.....	94
Board of Directors.....	94
<i>Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.</i>	<i>94</i>
Leadership	101
<i>Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.</i>	<i>101</i>
<i>Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.</i>	<i>107</i>
<i>Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.</i>	<i>120</i>
<i>Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.....</i>	<i>128</i>
Diversity and Cultural Competence	135
<i>Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.</i>	<i>135</i>
Workforce	139
<i>Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.</i>	<i>139</i>
<i>Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.</i>	<i>149</i>
Eligibility	155
<i>Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.....</i>	<i>155</i>

*Recommendation #18: Establish an expert body to develop recommendations for
VA care eligibility and benefit design.* 161

APPENDIX A: FINANCING THE VISION AND MODEL171

APPENDIX B: LEADERSHIP IMPLEMENTATION191

APPENDIX C: PILOT PROJECTS FOR EVALUATING EXPANDED CARE201

APPENDIX D: HISTORY AS A CONTEXT FOR SYSTEMIC TRANSFORMATION .207

APPENDIX E: THE EVOLVING HEALTH CARE INDUSTRY.....217

APPENDIX F: THE COMMISSION’S PROCESS225

APPENDIX G: VETERAN FEEDBACK.....243

APPENDIX H: ADDITIONAL RESOURCES253

APPENDIX I: ENABLING LEGISLATION261

APPENDIX J: COMPOSITION OF THE COMMISSION275

APPENDIX K: COMMISSION STAFF287

APPENDIX L: ACRONYM LIST289

LIST OF FIGURES

Figure 1. Projected Costs of Recommended Option	33
Figure 2. Disparities Among Veterans in the Incidence of Hepatitis C Virus.....	52
Figure 3. The Complicated Process of Meeting and Managing VHA’s Capital-Needs	64
Figure 4. VA IT Spending	69
Figure 5. Organizations Comprising VA’s Supply Chain.....	85
Figure 6. Diversity of Senior-Level Hires in VHA.....	111
Figure 7. Minority Women are Under Represented in Higher-Level Positions in VHA.....	112
Figure 8. At Each Leadership Level, Mastery of Leadership Competencies Increases.....	115
Figure 9. Proposed VHA Organizational Chart	126
Figure 10. Current VHA Organizational Chart	126
Figure A-1. Changes in Number of Veterans, Enrollees over a 20-year Period.....	172
Figure A-2. Projected Costs of Recommended Option.....	178
Figure A-3. Projected Costs of CDS Alternative 1	181
Figure A-4. Projected Costs of CDS Alternative 2.....	182
Figure A-5. Projected Costs of CDS Alternative 3.....	183
Figure A-6. Projected Costs of Keep Selected Services Scenario	184
Figure A-7. Projected Costs of Premium Support Scenario	186
Figure A-8. Projected Costs of Eligibility Expansion Scenario	187
Figure A-9. Cost of Hiring Additional RN Care Managers	188
Figure A-10. Projected Costs of Temporarily Covering Veterans with OTH Discharges	189

LIST OF TABLES

Table 1. VHA Care System Operations.....	5
Table 2. VHA Care System Operations.....	29
Table 3. Major Health Conditions in Racial/Ethnic Minority Groups.....	51
Table 4. Comparison of Health Outcomes by Race.....	52
Table 5. Overview of VHA Care System Governing Board.....	98
Table 6. Cultural Transformation Efforts in VA and VHA.....	103
Table 7. White Males are Over Represented in VHA SES Development Program, HCLDP	113
Table 8. Priority Groups.....	164
Table B-1. Organizational Health and Cultural Transformation	191
Table B-2. Recruitment, Retention, Development, and Advancement.....	193
Table B-3. Organizational Structure and Function.....	196
Table B-4. Performance Metrics and Management	199
Table B-5. Leadership Implementation: Human Capital Management	200
Table F-1. Workgroup Structure and Topics.....	231
Table F-2. Alignment Workgroup Activities.....	232
Table F-3. Health Care Operations Workgroup Activities.....	234
Table F-4. Data, Tools & Infrastructure Workgroup Activities	235
Table F-5. Leadership Workgroup Activities	237
Table F-6. VA Facility Site Visit Locations.....	240
Table F-7. SWOT Analysis of Commissioner Site Visit Observations	242
Table G-1. Veteran Profiles Developed by the VA Center for Innovation.....	246

COMMISSION ON CARE FINAL REPORT

THIS PAGE INTENTIONALLY LEFT BLANK

EXECUTIVE SUMMARY

Two years ago, a scandal over VHA employees' manipulation of data systems to cover up long appointment scheduling delays made headlines and left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. The White House appointed new leadership, including the secretary of veterans affairs (SECVA) and the undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The independent assessment included an examination of the hospital care, medical services, and other health care provided in VA medical facilities.¹ The legislation identified 12 specific areas for in-depth evaluation:

- Demographics
- Health Care Capabilities
- Care Authorities
- Access Standards
- Workflow–Scheduling
- Workflow–Clinical
- Staffing/Productivity
- Health Information Technology
- Business Processes
- Supplies
- Facilities
- Leadership

The *Independent Assessment Report* provided a detailed analysis of the assessment and associated findings. The Commission work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

In an effort to focus the Commission's recommendations and set the tone for subsequent change, the Commissioners developed a vision, a mission, and a set of values to drive reform as shown below. The vision provides the conceptual framework for the model of veterans' health care put forth in this report, and the mission and values shape the content of the recommendations.

Vision

Transforming veterans' health care to enhance quality, access, choice, and well-being.

- *Quality: Provide community-based, innovative care that drives improved outcomes.*
- *Access: Ensure timely access to the best providers for meeting veterans' health care needs.*

¹ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113–146, § 201(a)(1).

COMMISSION ON CARE FINAL REPORT

- *Choice: Integrate health care within communities to foster convenience and efficiency.*
- *Well-Being: Support veterans in achieving optimal physical and mental health.*

Mission

Provide eligible veterans prompt access to quality health care.

Values

- Provide veteran-centric care.
- Involve all stakeholders, and especially veterans and their families, in designing the evolving future health care for veterans.
- Assimilate veterans into the greater community.
- Create community-based integrated networks to improve health care access and choice for veterans.

The recommendations in this report acknowledge that although VHA provides health care that is in many ways comparable or better in clinical quality to that generally available in the private sector, it is inconsistent from facility to facility, and can be substantially compromised by problems with access, service, and poorly functioning operational systems and processes.

Some of these challenges are not exclusive to VHA, and reflect large-scale problems in the U.S. health system in general, such as acute shortages of primary care doctors and lack of health care capacity in poor and rural areas. Other challenges reflect deficiencies within VHA itself, in areas such as staffing, facilities, capital needs, information systems, healthcare disparities and procurement.

It is important to understand VA's long history as a health care provider, which has included previous cycles of crisis and renewal that offer lessons for the present. It is also important to consider how VHA can implement major reform in a manner that is sustainable. This report addresses both of these issues.

The Commission's focus on access to care clearly highlighted the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The report begins with an *Introduction* that addresses the controversy over veterans' health care and gives a brief description of the Commission's vision for improving it. There are three main recommendation sections: *Redesigning the Veterans' Health Care Delivery System*; *Governance, Leadership, and Workforce*; and *Eligibility*. Each section includes detailed discussions of the high-level areas in which change must occur in the respective areas to facilitate bold reform. The format for each discussion includes identification of the problem, the Commission's recommendations for addressing the problem, background information, analysis, and implementation steps for Congress, VA, and other agencies. This executive summary provides a brief overview of each of the recommendations.

For the ease of our readers, the appendices contain all additional content. Of particular interest are appendices on *Financing the Vision and Model*, *Leadership Implementation*, *History as a Context for Systemic Transformation*, *Veteran Feedback*, and *Additional Resources*. These and other appendices provide policymakers and those charged with implementing the plan with a clear picture of the rationale for the recommendations and the context that frames them.

Recommendations

The Commission does not intend for these recommendations to be piecemeal fixes to everyday problems. Instead, they are presented as the foundation for far-reaching organizational transformation that adheres to a systems approach. The Commission's recommendations comprise the essential elements for such transformation.

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Due to changing veteran demographics, increasing demand for VHA care in some markets and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was designed to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

The Commission Recommends That . . .

- VHA Care System governing board (see recommendation on p. 94) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.

COMMISSION ON CARE FINAL REPORT

- Integrated community-based health care networks be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.
- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

The recommendations above work together to support the VHA Care System, as outlined in Table 1 below.

Table 1. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.²

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.³ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁴

² RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016,

http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

³ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016,

http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁴ *Ibid.*, 95.

COMMISSION ON CARE FINAL REPORT

VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

The Commission Recommends That. . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally supported programs.

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁵ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶

As part of the MyVA initiative, the Secretary of Veterans Affairs has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁷ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁸

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a revised clinical-appeals process.

⁵ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁸ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁹

VHA has a program of system engineering – Veterans Engineering Resource Center (VERC) – that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to identify proactively problem areas within the system and offer assistance.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs*, Assessment F (Workflow—Clinical), 14 and A-2, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

COMMISSION ON CARE FINAL REPORT

A systematic review of VHA in 2007 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.¹⁰ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues – the Health Equity Action Plan (HEAP) – but it has not been fully implemented.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.¹¹

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Veterans who turn to VHA to meet health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of those barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks holds the promise of markedly improving veterans' access to care. That promise cannot be realized without transformative changes to VHA's capital structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of building out the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as

¹⁰ Somnath Saha et al., *Racial and Ethnic Disparities in the VA Healthcare System: A Systematic Review*, U.S. Department of Veterans Affairs, Health Services Research & Development Service, June 2007, accessed June 22, 2016, <http://www.hsrd.research.va.gov/publications/esp/RacialDisparities-2007.pdf>.

¹¹ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

much control as possible to drive the process to ensure that all facility plans are fully integrated with the strategic vision for the VHA Care System.

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meets its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission (BRAC) process to be implemented as soon as practicable. The Commission recommends the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems; enables scheduling, billing, claims, and payment, and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹² VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, VHA lacks an experienced senior health care IT leader focusing on the strategic health care IT needs of veterans.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing

¹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

COMMISSION ON CARE FINAL REPORT

and implementing a comprehensive health IT strategy and developing and managing the health IT budget.

- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.¹³

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.

¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center, and similar problems at multiple other VA medical centers, had both direct and indirect causes. Weak governance was found to be among those indirect causes.¹⁴ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.¹⁵ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”¹⁶ The governance limitations made evident in the Phoenix scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,¹⁷ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with competing demands”¹⁸ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act (FACA) and be structured based on the key elements included in Table 5.

¹⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

COMMISSION ON CARE FINAL REPORT

- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

High-performing organizations have healthy cultures in which diverse staff feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government. For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report on it to the CVCS and the new VHA Care System board of directors (see governance discussion in the previous section).

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and

promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an OMB management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and the functions overlap or are duplicated. The role of the VISN is not clear, and the delegated responsibilities of the medical center director are not defined.

The Commission Recommends That . . .

- VHA redesign VHACO to create high-performing support functions that serve VISNs and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the CVCS with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report.

COMMISSION ON CARE FINAL REPORT

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

To achieve the Commission's vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set—identical to private-sector standards—will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes to veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders' performance not just on *what* they achieve but *how* they achieve it.

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Personnel Performance Management System

- VHA create a new performance management system appropriate for health care executives, tied to health care executive competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of

these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veterans' care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.

COMMISSION ON CARE FINAL REPORT

- Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

Recommendation #16: Require top executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Effective planning for and management of human capital are core enabling requirements for any business: If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation's entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the chief of VHA Care System.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.

- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers, which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

In some cases, individuals have been dismissed from military services with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury [TBI], posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an OTH discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Although VHA continues to offer the promise of health care to all eligible veterans, its capacity to meet that promise is constrained by appropriated funding.¹⁹

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use

¹⁹ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

COMMISSION ON CARE FINAL REPORT

underutilized VHA providers and facilities, providing payment through private insurance.

- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

Conclusion

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, though, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement and in where and how care is delivered. VHA must keep pace with, and even be a leader in, these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand access to reflect not only timeliness, but care quality, and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone: Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report* emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The Commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term transformation, the Commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the nation's obligation to those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission fully acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the Commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For

example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net. Even considering these strengths, some may question how a system beleaguered with the problems VHA faces can achieve lofty transformation goals. This is not the first time VHA has faced challenges; however, and history has demonstrated that with appropriate structure and strategies in place, transformation can be achieved and sustained.

Transformation is a difficult process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. The Commission's recommendations in some areas acknowledge VHA's efforts to begin the transformation process and suggest that where these efforts align with the Commission's recommendations, they should be sustained. Reaping the fruits of transformation will take more than a single Congress or a single 4-year administration. For this reason, the Commission strongly recommends a new governance model and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission's recommendations, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

COMMISSION ON CARE FINAL REPORT

THIS PAGE INTENTIONALLY LEFT BLANK



INTRODUCTION

Two years ago, a scandal over VHA employees manipulating data systems to cover up long delays in scheduling care left the veterans' health care system reeling. The White House and Congress investigated the situation and identified chronic management and system failures, along with a troubled organizational culture. In response, the White House appointed new leadership, including the secretary of veterans affairs (SECVA) and undersecretary of health (USH), and Congress enacted substantial legislation that established a temporary program, the *Choice Program*, to fund expanded community care to alleviate wait times; directed a comprehensive independent assessment of VHA care delivery and management systems; and established this commission to review that assessment, examine access to care, and look more expansively at how veterans' care should be organized and delivered during the next 2 decades.

The Commission on Care's work during the past 10 months was informed by the *Independent Assessment Report*, as well as by 26 days of public meetings (held in 12 sessions) with testimony by a broad range of experts and stakeholders, intensive deliberations, site visits to VHA facilities, and very importantly by the wide-ranging experience and expertise of commission members appointed by congressional leaders and the President.

The charge given this Commission, with its emphasis on access to care, reflects the need for a long-range strategic evaluation of the veterans' health system. Access problems were the primary catalyst for the law establishing this body, and an examination of access has necessarily been central to the Commission's work; however, Congress wisely directed the Commission to undertake a strategic examination as well.

The next 20 years will see continued dynamic change in health care, well beyond the Commission's capacity to forecast the future. What is clear, however, is that the concept of access to care is itself undergoing marked change. The potentially explosive growth of telemedicine, increasing emphasis on preventive care, and likely proliferation of technologies that permit routine home-based health monitoring and care of patients with chronic illnesses will dramatically affect access needs. We are also witnessing profound changes in the nature of patient-provider engagement, and in where and how care is delivered. VHA must keep pace with, and even be a leader, in these changes.

Patient-access is a sharp lens through which to gauge how well a health system is functioning, particularly if we understand *access* to reflect not only timeliness, but care quality and patient expectations. Providing veterans timely care remains a challenge today, notwithstanding establishment of the *Choice Program* and VHA leadership's focus on improving access. Access is not a problem for VHA alone; Delivering timely care is challenging for many providers and health systems, in part due to the unavailability of providers in some communities and national shortages of some categories of health professionals.

For VHA, an important conclusion is that providing timely access to care is not simply a matter of increasing staffing, modernizing IT systems, installing new leadership, or any other single effort, although all of these changes are needed. As the *Independent Assessment Report*

COMMISSION ON CARE FINAL REPORT

emphasized, multiple systemic problems have contributed to VHA's access problems, and an integrated systems approach is essential to address the myriad issues affecting access to care and the service veterans receive.

The commission's report underscores the importance of transforming VA health care delivery and the systems that underlie it. In employing the term *transformation*, the commission means fundamental, dramatic change—change that requires new direction, new investment, and profound reengineering. Some will question that view, and perhaps challenge the notion that the nation should invest further in the VA health care system. None, however, should question the obligation owed those who sustained injury or illness in service, or who are at increased health risk as a result of deployments to combat zones or other service-related experiences.

In this report, the Commission acknowledges the deep problems the *Independent Assessment Report* described. Importantly, though, the commission recognizes the VA health care system has valuable strengths, including some unique and exceptional clinical programs and services tailored to the needs of the millions of veterans who turn to VA for care. For example, VHA's behavioral health programs, particularly with their integration of behavioral health and primary care, are largely unrivalled, and profoundly important to many who have suffered from the effects of battle and for whom VHA is a safety net.

Others may question how a system with the range of problems VHA faces can meaningfully improve, let alone realize a transformation. Mindful of its 20-year charge, the Commission notes that VA health care faced similar challenges 20 years ago and underwent a historic transformation. The long history of the VA health care system has seen highs and lows. Among the lessons in that history is that the mission—to care for those who have borne the battle—is not only powerful, but enduring. History has demonstrated that transformation can be achieved, but also that structures and strategies for sustainability must be built into the framework.

As the commission report emphasizes, transformation is difficult. It is a process that will require careful stewardship, sustainable leadership, and unwavering focus and commitment to the long-term vision and strategy. VHA has begun some of this work; our recommendations in some areas acknowledge VHA's efforts and suggest that where they are aligned with the Commission's recommendations, they should be sustained. The fruits of the transformation, though, will not be realized over the course of a single Congress or a single 4-year administration. For this reason, the Commission, strongly recommends a new form of governance and an extended term for the leader of the VHA Care System to sustain a continuing transformation. Even should VHA implement all the Commission recommends, it will not succeed in transforming on its own; it will require the full support from both the White House and Congress. Our nation's veterans deserve no less.

COMMISSION RECOMMENDATIONS

Redesigning the Veterans' Health Care Delivery System

The VHA Care System

Recommendation #1: Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which veterans will access high-quality health care services.

Problem

Due to changing veteran demographics, increasing demand for VHA care in some markets, and declining demand in other markets, more veterans being adjudicated as having service-connected conditions, aging facilities, provider shortages and vacancies, and other factors, VHA faces a misalignment of capacity and demand that threatens to become worse over time. Some facilities and services have low volumes of care that can create quality concerns, and in high demand areas, VHA often lacks the capacity to avoid lengthy wait times and other access issues.

With the passage of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Congress tasked VHA with creating the temporary *Choice Program*. It was intended to alleviate access issues by allowing for greater use of community care for enrolled veterans who meet the law's wait-time or distance-to-a-VHA-facility requirements.

The Commission Recommends That . . .

- VHA Care System governing board (see Recommendation #9) develop a national delivery system strategy, including criteria and standards for creating the VHA Care System, comprising high-performing, integrated, community-based health care networks, including VHA providers and facilities, Department of Defense and other federally-funded providers and facilities, and VHA-credentialed community providers and facilities.
- Integrated, community-based health care networks be developed with *local* VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.
- Integrated, community-based health care networks must include existing VHA special-emphasis resources (e.g., spinal cord injury (SCI), blind rehabilitation, mental health, prosthetics, etc.). In areas for which VHA has special expertise, VHA should also play the role of enhancing care in the local communities by collaborating with community care providers to implement services that may not exist, focused on the needs of veterans (e.g., expansion of integrated primary care/mental health care).
- Networks be built out in a well-planned, phased approach, overseen by the new governing board, which determines the criteria for the phases to ensure effective execution of the strategy.

Recommendations continue on next page. =>

COMMISSION ON CARE FINAL REPORT

Both the design and implementation of the law have proven to be flawed. VHA must instead establish high-performing, integrated, community-based health care networks, to be known as the VHA Care System.

Background

VHA has long had authority to purchase hospital care and medical services based on geographic inaccessibility or VHA's lack of a required service.²⁰ In 2013, VA moved beyond the use of individual purchased-care authorizations to regional contracting under the Patient-Centered Community Care (PC3) Program.²¹ In all cases, purchased care was a secondary means of providing care, to be used "when VA health care facilities are not feasibly available."²² Even before the creation of the *Choice Program* in 2014, some 10 percent of VHA medical spending went for purchased-care services.

When Congress enabled what became known as the *Choice Program*, it tasked VHA with implementing a fundamentally new mechanism for purchasing care. Unlike traditional purchased-care authority (which still exists), the *Choice Program* promises veterans who meet specific geographic or wait-time-related criteria that they can elect to receive treatment from within a network of a community providers.²³

Under the current *Choice Program*, however, most VHA patients are promised little or no actual choice of providers outside VHA. To be eligible for the program, VHA patients must meet the following criteria:²⁴

The Commission Recommends That . . .

<= Recommendations continued from previous page.

- VHA credential community providers. To qualify for participation in community networks, providers must be fully credentialed with appropriate education, training, and experience, provide veteran access that meets VHA standards, demonstrate high-quality clinical and utilization outcomes, demonstrate military cultural competency, and have capability for interoperable data exchange.
- Providers in the networks be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS).
- The highest priority access to the VHA Care System be provided to service-connected veterans, and low-income veterans also be of high priority.
- The current time and distance criteria for community care access (30 days and 40 miles) be eliminated.
- Veterans choose a primary care provider from all credentialed primary care providers in the VHA Care System.
- All primary care providers in the VHA Care System coordinate care for veterans.
- The VHA Care System provide overall health care coordination and navigation support for veterans.
- Veterans choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider.

²⁰ Contracts for Hospital Care and Medical Services in Non-Department Facilities, 38 U.S.C. § 1703(a).

²¹ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 37, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

²² Non-VA Medical Care Program, VHA Directive 1601, (2013).

²³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014).

²⁴ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. 113-146, 128 Stat. 1754, (2014), as amended by Construction Authorization and Choice Improvement Act, Pub. L. No. 114-19, 129 Stat. 215, (2015). The Independent Assessment proposed that VA should "Develop and implement more sensitive standards of geographic access to care. VA should compare the 'one-size-fits-all' approach of driving distance to alternative standards that are more sensitive to differences between Veteran subgroups, clinical populations, geographic regions, and individual facilities. This

- Live more than 40 miles from the closest VHA facility with a full-time primary care provider
- Cannot be seen within 30 days of the date veterans' providers indicate they need to be seen.
- Cannot be seen within 30 days of veterans' preferred appointment date if providers have not provided a specific appointment date.

This standard is difficult to reconcile with other statutory priorities for VA care.²⁵ For example, under the *Choice Program*, a veteran with severe service-incurred health conditions may have no access to providers outside VHA, yet a veteran with no service-related disabilities does have such a choice.²⁶ Implementing the *Choice Program* has posed challenges, including difficulties arising from overlapping, but fundamentally different, care-purchasing authorities. Veterans, VHA staff, and community providers²⁷ have been confused because of conflicting requirements and processes in eligibility rules, referrals and authorizations, provider credentialing and network development, care coordination, and claims management.²⁸

Adding to the confusion is the fact that VHA, facing a 90-day deadline for implementing the program, outsourced the creation and management of its provider networks to two private contractors, thus blurring lines of responsibility and leaving both patients and providers confused about who exactly holds responsibility for what. In execution, the program has aggravated wait times and frustrated veterans, private-sector health care providers participating in networks, and VHA alike.²⁹

In October 2015, VA submitted a report to Congress that proposed legislation to harmonize the different purchased-care authorities into a single approach.³⁰ VA's report also set out a plan for establishing high-performing networks. The report acknowledged that "[n]o organization can excel at every capability," and that "[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers."³¹ As further articulated by Dr. David Shulkin, USH:

assessment highlighted the importance of time spent driving, mode of transportation, traffic, and availability of needed services as key considerations in assessing geographic access to care."

²⁵ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705.

²⁶ Ibid.

²⁷ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, 43, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf. Pete Henry, retired VA medical center director, response to questions about the challenges facing field officials, email to Commission on Care staff, January 18, 2016.

²⁸ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

²⁹ "Despite \$10B 'Fix,' Veterans are Waiting Even Longer to See Doctors," Quil Lawrence, Eric Whitney, and Michael Tomsic, accessed May 16, 2016, <http://www.npr.org/sections/health-shots/2016/05/16/477814218/attempted-fix-for-va-health-delays-creates-new-bureaucracy>.

³⁰ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 30, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

³¹ Ibid., 18.

COMMISSION ON CARE FINAL REPORT

It's become apparent that the VA alone cannot meet all the health care needs of U.S. veterans. The VA's mission and scope are not comparable to those of other U.S. health systems. Few other systems enroll patients in areas where they have no facilities for delivering care. Fewer still provide comprehensive medical, behavioral, and social services to a defined population of patients, establishing lifelong relationships with them. These realities, combined with the wait-time crisis, have led the VA to reexamine its approach to care delivery . . . [A]ddressing veterans' needs requires a new model of care: rather than remaining primarily a direct care provider, the VA should become an integrated payer and provider. This new vision would compel the VA to strengthen its current components that are uniquely positioned to meet veterans' needs, while working with the private sector to address critical access issues.³²

Analysis

VHA needs systemic transformation, and merely clarifying and simplifying the rules for purchased care, as proposed in the *Independent Assessment Report*, is not sufficient to achieve that goal. VHA must replace the arbitrary eligibility requirements and unworkable clinical and administrative restrictions of current purchased programs with the new VHA Care System, available to all enrolled veterans.

The VHA Care System is defined as VHA employed providers and facilities; Department of Defense (DoD) and other federally-funded providers and facilities; and community-based, VHA-credentialed community providers and facilities, forming integrated networks to deliver high-quality and high-access care to enrolled veterans across the United States. VHA may establish the networks with the use of national contractors or with internal resources, but networks should be developed with local VHA leadership input and knowledge to ensure their composition is reflective of local needs and veterans' preferences.

This new delivery model must preserve critical VHA programs and competencies that are unique to VHA or that are of higher quality or greater scope than is available in the private sector, either locally or nationally³³ They include specialized behavioral health care programs, integrated behavioral health and primary care (in patient-aligned care teams), specialized rehabilitation services, spinal cord injury centers, and services for homeless veterans.³⁴ These and similar programs and services are core competencies and special capabilities that serve the needs of combat veterans, veterans with conditions incurred or aggravated in service, and veterans reliant on safety-net services and supports.³⁵ Because of its unique capabilities and competencies, VHA should play an important role in expanding and enhancing the care of veterans across the United States by collaborating with local network providers to improve the

³² David J. Shulkin, "Beyond the VA Crisis — Becoming a High-Performance Network," *New England Journal of Medicine*, 374, (2016): 1003-1005, accessed June 15, 2016, <http://doi.org/10.1056/NEJMp1600307>.

³³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

³⁴ Special capabilities like spinal cord injury care, which draw from specialty care available in the full-service hospitals in which they are currently provided, merit continued support and investment. Thus, in instances where VHA might no longer operate a full-service hospital that had once housed a spinal cord injury center, it would need to establish community partnerships to assure veterans would continue to receive the same high quality care.

³⁵ David J. Shulkin, "Why VA Health Care Is Different," *Federal Practitioner*, 33, no. 5 (2016): 9-11, <http://www.fedprac.com/home/article/why-va-health-care-is-different/c8da5ba1261bdbe726bddcbceea81f27.html>.

availability and quality of care in areas especially needed by veterans, such as mental health and rehabilitation.

Management and Oversight

VHA Care System networks will be built out in a well-planned, phased approach overseen by the new governing board, which will determine the criteria and sequencing for the phases, to ensure effective execution of the strategy. The timing and phasing criteria may include veteran service needs, access issues, quality issues, facility issues, and IT capabilities.

The networks within the VHA Care System will require ongoing management and evaluation of their performance. This process will be the responsibility of VHA management and board, with board oversight of network performance.

The governing board will oversee the budget for the VHA Care System. Local leadership will provide input on funding, and the local networks will determine their funding needs and submit their respective requests to the chief of VHA Care System (CVCS), formerly the undersecretary of health for VHA. The governing board will recommend to Congress the budget required to implement the VHA Care System, with multiyear appropriations. The local network leaders will have the flexibility to manage their respective network budgets based upon local needs. A key element of the new system will be combining a national strategy and local flexibility for managing the budget to allow for effective decision making to ensure veterans' needs are met.

Provider Payment

Providers in the networks should be paid using the most contemporary payment approaches available to incentivize quality and appropriate utilization of health care services (i.e., using Medicare Access and CHIP Reauthorization Act of 2015 [MACRA] physician payment methodology being proposed by CMS). MACRA is intended to move the health care industry away from a fee-for-service model to value-based payments.³⁶ Such a system is expected to drive improved quality and lower costs.³⁷

Care Administration

From a strategic perspective, service-connected disabled veterans should receive the highest priority access to the VHA Care System. This principle should guide access to all types and points of care. Veterans with limited financial means should also have high priority. If needed, cost sharing (applicable only to those who are non-service-connected disabled and not financially needy) can provide a means for offering broader choice. The current time and distance criteria for community care access (30 days and 40 miles) should be eliminated. VISN geography should also be eliminated as a factor in determining where veterans can access care. Eligible veterans should be permitted to receive care at any facility and by any provider in the VHA Care System, whether in a veteran's home VISN or not.

Choice and Care Coordination

The topic of choice was the most contentious issue considered by the Commission. Some Commissioners advocated complete choice of providers for veterans, with no requirement for

³⁶ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

³⁷ Ibid.

COMMISSION ON CARE FINAL REPORT

care coordination by primary care physicians. Others advocated for a tightly managed model with VHA controlling access to community providers, as is done today. After considering the costs of various design options, the importance of care coordination, and the need for greater veteran access to both primary care and specialty care services, the Commission agreed to the following design principles:

- VHA will establish and credential community networks with a focus on quality of providers, access to comprehensive services, and utilization of VHA resources.
- Veterans will have complete choice of primary care providers within the VHA Care System.
- All primary care providers in the VHA Care System (including VHA providers, DoD and other federally funded providers, and community providers) will coordinate veterans' care.
- Specialty care will require a referral from a primary care provider.
- VHA will assume overall responsibility for care coordination and navigation for all enrolled veterans.

Quality of care must be a core element of network design and consistently monitored with metrics that are routinely used by the private sector. Accordingly, VHA must adopt standards that both ensure networks are composed of high-quality providers and set appropriate expectations of those providers. Critically, all providers in the networks must have fully interoperable IT platforms to allow for complete data exchange. Providers must work together to maximize patients' well-being using evidence-based protocols of care.

Lack of coordination among providers is a major quality and patient-safety issue throughout the U.S. health care system. It is important for VHA to coordinate the care it provides because it serves an especially vulnerable population that has more chronic medical conditions, behavioral health conditions, and individuals of lower socioeconomic status than the general medical population.³⁸ Veterans who receive health care exclusively through VHA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers.³⁹

³⁸ Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>.

³⁹ "The Impact of the Affordable Care Act on VA's Dual Eligible Population," Patricia Vandenberg et al., Department of Veterans Affairs, accessed June 2, 2016, <http://www.hsrd.research.va.gov/publications/forum/apr13/apr13-1.cfm>. Kenneth Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8, (2012): 789-790, accessed June 20, 2016, <http://doi.org/10.1001/jama.2012.196>. Brigham R. Frandsen et al., "Care Fragmentation, Quality, and Costs Among Chronically Ill Patients," *American Journal of Managed Care*, 21, no. 5, (2015): 355-362, accessed June 20, 2016, <http://www.ajmc.com/journals/issue/2015/2015-vol21-n5/care-fragmentation-quality-costs-among-chronically-ill-patients>. Chuan-Fen Liu et al., "Use of Outpatient Care in Veterans Health Administration and Medicare among Veterans Receiving Primary Care in Community-Based and Hospital Outpatient Clinics," *Health Services Research*, 45, no. 5 part 1, (2010): 1268-1286, accessed June 20, 2016, <http://doi.org/10.1111/j.1475-6773.2010.01123.x>.

VHA Care System will operate as outlined in Table 2 below.

Table 2. VHA Care System Operations

Key Component	Expectations
Choice	<ul style="list-style-type: none"> ▪ Veterans can choose a primary care provider from all credentialed primary care providers in the VHA Care System. ▪ Veterans can receive their care at any VHA Care System location across the country with coordination by their primary care provider.
Care Coordination	<ul style="list-style-type: none"> ▪ All primary care providers in the VHA Care System must coordinate care for veterans. Specialty care is exclusively accessed through referrals from primary care providers. ▪ Veterans can choose their specialty care providers from all credentialed specialty care providers in the VHA Care System with a referral from their primary care provider. ▪ Although primary care is traditionally defined as internal medicine or family practice, VHA may designate other specialty providers as primary care coordinators based on veterans' specific health needs (e.g., endocrinologists for diabetic patients, neurologists for patients with Parkinson's disease, OB/GYN for female patients). ▪ VHA will have overall responsibility of ensuring care coordination for veterans, including complex care navigation.

Scope of Provider Networks

In setting up networks within the VHA Care System, VHA must make critical tradeoffs regarding their size and scope. For example, establishing broad networks would expand veterans' choice, yet would also consume far more financial resources (i.e., taxpayer dollars) due to increased utilization or cost shifting. Currently, money VHA spends on expanding choice is not available to spend on other programs and services vital to its mission.⁴⁰

Health plans commonly limit the size and scope of networks as a cost-management tool, offering insurance products with narrow networks (managed care plans) or more open networks (preferred provider plans). Well-managed, narrow networks can maximize clinical quality by requiring participating clinicians to adhere to evidence-based protocols of care.⁴¹ Achieving high quality and cost effectiveness may constrain consumer choice. A patient's preferred doctor, clinic, or hospital may not be part of that smaller network or the narrow network may not offer sufficient geographic access for some patients.⁴²

VHA must balance these competing considerations. In doing so, it faces a variety of options. In addition to the scope of networks, for example, is the question of whether and how VHA will play a role in steering patients to different providers within the networks. This is another area involving tradeoffs among competing values and considerations. Private-sector health plans

⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 23 accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴¹ "What Tier Networks Will Mean to You," Ken Terry, accessed June 2, 2016, <http://medicaleconomics.modernmedicine.com/medical-economics/content/what-tiered-networks-will-mean-you>.

⁴² Ibid. U.S. Congress, House of Representatives, Committee on Ways and Means, Subcommittee on Health, *Hearing on "Health Care Consolidation"*, 112th Congress, 1st Session, (2011), (Statement of Paul B. Ginsburg, President, Center for Studying Health System Change, Research Director, National Institute for Health Care Reform), accessed June 2, 2016, http://waysandmeans.house.gov/UploadedFiles/Ginsburg_Testimony_9-9-11_Final.pdf.

COMMISSION ON CARE FINAL REPORT

often require all specialty care to be preapproved through a referral from a primary care physician. Managed care plans may also use prospective and concurrent utilization review and care management for hospitalization. For prospective reviews, patients must receive approval from their health plan before being admitted to the hospital to ensure the admission is clinically appropriate. Plans may also use concurrent utilization or case management for inpatient care to ensure the care and tests ordered and the length of stay in the hospital are appropriate.⁴³

The Commission carefully weighed these issues in recommending an approach. The Commission considered the effect of cost using various configurations of VHA services and community delivered services (CDS). Options considered by the commission include the following:

- **Recommended Option:** This option provides an integrated network of VHA, DoD and other federally funded providers, and community providers, credentialed by VHA. It requires veterans to attain a referral from their primary care provider to access specialty care.
- **CDS Alternative 1:** The main difference between this option and the *Recommended Option* is primary care, inpatient medical and surgical care, and some standard specialty care would not be eligible for CDS networks and would be accessed within VHA unless the *Choice Program* distance exception applies.
- **CDS Alternative 2:** The division of care between VHA providers and CDS network providers would be the same as for *CDS Alternative 1*; however, veterans would only need to consult their primary care provider before seeking specialty care, rather than obtaining a referral.
- **CDS Alternative 3:** This option would combine the broad network in the *Recommended Option*, but would have no referral or consultation requirement; thus, it would be an extremely generous benefits package.
- **Premium Support:** Under this scenario, enrollees who are younger than 65 would choose a subsidized insurance premium with cost sharing. Access to VA services, including special services, would be eliminated.
- **Eligibility Expansion:** Under this scenario the VA health care system would expand to allow all veterans, regardless of priority group.
- **Other-Than-Honorable Discharges:** A policy change for which individuals with other-than-honorable (OTH) discharge is outlined in Recommendation #17. This option would allow temporary eligibility for VA health care to those with an OTH discharge until the adjudication process to determine long-term eligibility took place.

⁴³ Paul B. Ginsburg, "Achieving Health Care Cost Containment Through Provider Payment Reform that Engages Patients and Providers," *Health Affairs*, 32, no. 5, (2013): 929-934, accessed June 20, 2016, <http://doi.org/10.1377/hlthaff.2012.1007>. While these approaches can help keep costs down, patients, doctors and hospitals can experience the process as bureaucratic interference in clinical care. To implement utilization management, health plans usually include a strong clinical appeals process that both doctors and patients can access to question the decisions made by administrators.

Below is a more detailed summary of the Commission's *Recommended Option*. Additional information, including cost projections for all of the options above, can be found in Appendix A.

Cost Model for Commission Recommended Option

This option would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VHA. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in a substantially different way than by VHA).⁴⁴ In 2014, 68 percent of care would have been eligible for CDS networks at current VHA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network (i.e., from any provider in the VHA Care System). In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

Both CDS networks and traditional Care in the Community (CITC) are priced at Medicare allowable rates by matching Medicare fee schedule data to VA Health Service Categories.⁴⁵ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities. For care shifting into the CDS networks, we assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance; those costs are not modeled.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a provider in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and

⁴⁴ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health, and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

⁴⁵ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

COMMISSION ON CARE FINAL REPORT

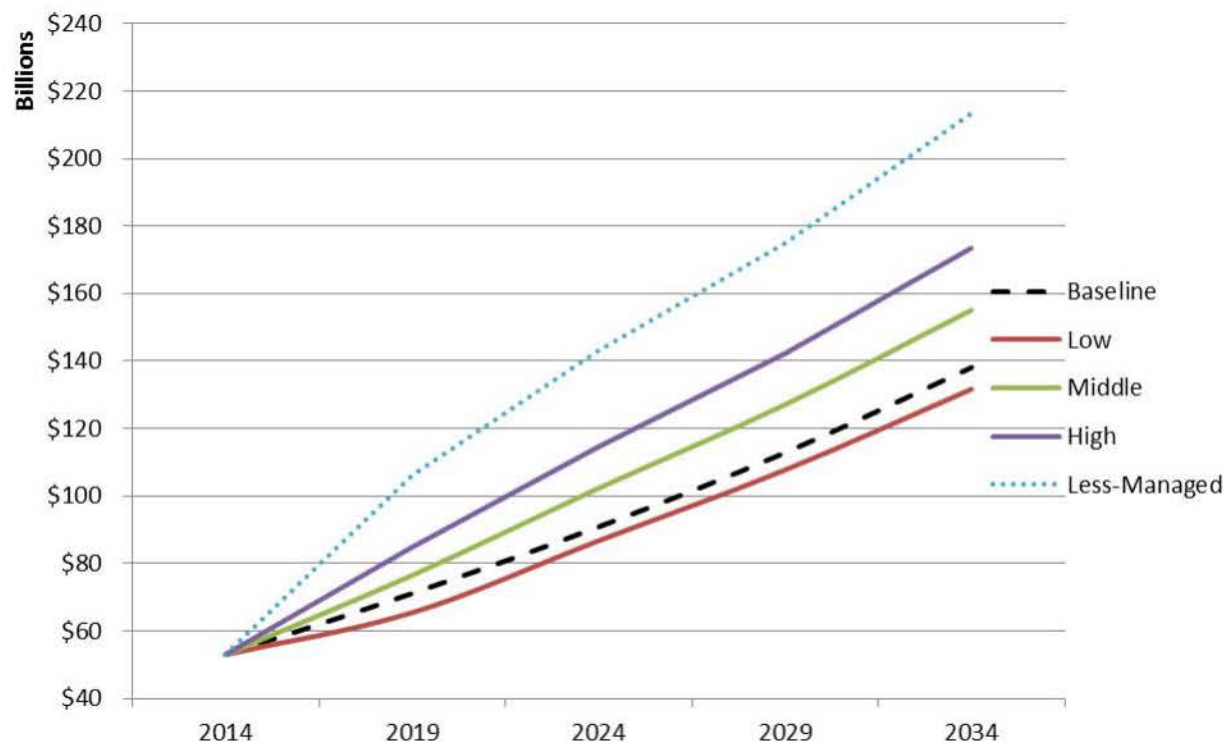
20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was formerly subject to sizable cost sharing with private insurance or Medicare and now would be subject to little, if any, cost sharing associated with VA-financed care.

There are a number of caveats associated with our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects on quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. Finally, estimates do not include administrative costs associated with CDS networks; these costs could be substantial.

Figure 1 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

This model is described more fully in Appendix A, along with models for a range of other options, some of which are previously described in this section. Consult Appendix A for more details on the technical assumptions necessary to understand the results presented here. The assumptions and caveats detailed in Appendix A play a critical role in our estimates, and any deviation from these assumptions could substantially affect the estimates.

Figure 1. Projected Costs of Recommended Option



Mitigating Risks

Choice involves tradeoffs. Reducing drive times to see a doctor may lead to longer wait times, for example, if it induces substantially more veterans to seek more care.⁴⁶ VHA reliance on contracting could also have unintended consequences for already underserved communities. Providers in such communities who join the local VHA network may decide to limit the number of Medicare and Medicaid patients they accept into their practices. In other, highly concentrated health care markets, which are increasingly common throughout the United States, VHA may not be able to contract for care in the community except at higher prices.⁴⁷ Such circumstances underscore the importance of VHA retaining the option of building its own capacity.

Policymakers must also carefully weigh concerns that leaders of seven major veterans organizations expressed in a recent joint letter in which they warned “choice should never be the ultimate goal of a health care system designed to meet the unique needs of veterans.”⁴⁸ These organizations do not support providing unfettered choice, and the VSO leaders stated that “any health care reform proposal that elevates the principle of ‘choice’ above all other clinical considerations would have severe consequences for veterans who rely on VA, resulting

⁴⁶ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 284, accessed May 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁴⁷ David M. Cutler and Fiona Scott Morton, “Hospitals, Market Share, and Consolidation,” *Journal of the American Medical Association*, 310, no. 18, (2013): 1964-1970, accessed June 20, 2016, <http://doi.org/10.1001/jama.2013.281675>.

⁴⁸ Garry J. Augustine, Disabled American Veterans et al., letter sent to Commission on Care, April 29, 2016.

COMMISSION ON CARE FINAL REPORT

in less ‘choice’ rather than the intended desire for more health care options for many disabled veterans.”⁴⁹

The Commission has addressed this concern in several ways, including the following:

- recommendations to substantially improve VHA operations, thereby enhancing the attractiveness of using VHA providers and facilities by enrolled veterans
- VHA control of network design
- VHA Care System governing board oversight of network execution and phasing
- high standards for community provider participation, including credentialing, military competence, and quality and utilization performance
- VHA oversight of care coordination and navigation
- requirement of primary care referral for specialty care

The Commission recognizes that greater choice of provider can result in higher utilization of health care services, which increases costs. This risk can be mitigated by recommendations in this report that will produce cost savings. To incentivize cost mitigation, all cost savings associated with improved efficiency and operations should be reinvested into the VHA Care System. Examples of cost mitigation strategies include the following:

- recovering third-party payments owed to VHA more effectively
- maintaining VHA as a secondary payer when veterans have other health insurance and treatment is for non-service-connected care
- increasing cost-sharing or changes in eligibility and/or benefit design could also substantially contain the projected costs of increasing provider-choice
- reducing fixed costs of underutilized facilities and services
- managing the supply chain to produce cost savings
- improving facilities to increase provider productivity (e.g., increase in outpatient exam rooms)
- adopting information technology that improves the quality and efficiency of care

Effectively implementing and managing integrated networks will require extensive changes in the governance and leadership of VHA, as well as flexible and smart procurement policies and

⁴⁹ Ibid.

contracting authorities, as discussed elsewhere in this report. The highest priority for standing up networks should be locations where VHA quality of care is deficient or capacity is strained.⁵⁰

Where capacity constraints exist within networks, first priority for care should go to those veterans with greatest medical need, followed by service-connected disabled veterans and indigent veterans.⁵¹ VHA should develop processes and procedures for insuring that veterans have the knowledge and assistance they need to make informed health care decision and to navigate effectively through the expanding health care networks. By employing strategies proven by other managed care plans, VHA will find administrative means to guard against inappropriate treatment, wasteful spending, and fraud.

As many surgical and medical procedures that previously required inpatient hospital stays have routinely become outpatient procedures, there continues to be a substantial shift from inpatient to outpatient care.⁵² Consequently, to ensure improved access to care for veterans, the VHA Care System and long-term plans for facilities should focus on creating a robust ambulatory network and reshaping inpatient resources to match expected demand. Additionally, to inform veterans' and providers' decisions and create increased accountability for performance, all VHA and community network providers and facilities must provide transparent information on inpatient and outpatient quality, service, and access using the same performance metrics, including those used by Medicare.

Implementation

Legislative Changes

- Enact legislation amending 38 U.S. Code, Chapter 17 to consolidate existing purchased-care authorities and authorize the SECVA to furnish enrolled veterans needed hospital care and medical services through agreements with providers the SECVA deems meet quality standards the SECVA will establish. Veterans would be eligible for community care on the same basis as for VHA-furnished care, and current wait time and geographic distance criteria should no longer be applicable.

VA Administrative Changes

- Develop national policy to govern local establishment of networks, and in doing so, focus its design and long-term planning on creating a robust ambulatory capability and reshaping inpatient resources to match expected demand.
- Establish standards that community providers must meet to qualify for participation in community networks, to include becoming fully credentialed, meeting patient-access criteria, demonstrating high-quality clinical outcomes and appropriate use decisions, demonstrating military cultural competency, and having capability for interoperable data exchange.

⁵⁰ Information on what medical centers are deficient in their care is available, for example, from the VHA's own Strategic Analytics for Improvement and Learning (SAIL) data.

⁵¹ It would seem prudent to begin such phased development by piloting that effort, and limiting the scope of unfettered choice to service-connected veterans.

⁵² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

COMMISSION ON CARE FINAL REPORT

- Establish systems to ensure that all primary care providers in the VHA Care System can effectively coordinate veterans' care.
- Provide veterans navigation services for complex care needs, including information needed by patients and their families for informed decision making about treatments and providers. Navigation services should assist veterans and their families with eligibility, cost-sharing, and other administrative issues.
- Establish policies and procedures to ensure that VHA provider as well as community providers within each network, provide transparent information (using the same metrics) on care-quality, service, and access.
- Eliminate the practice of cross-country referrals if quality care is available locally.
- Employ the most current payment approaches that incentivize quality and appropriate use of health care services.

Other Department and Agency Administrative Changes

- None required.

Clinical Operations

Recommendation #2: Enhance clinical operations through more effective use of providers and other health professionals, and improved data collection and management.

Problem

A shortage of providers and clinical managers, combined with inadequate support staff and policies that fail to optimize the talents and efficiency of all health professionals, detract from the effectiveness of VHA health care.

The problem starts with inadequate numbers of providers. Ninety-four percent of VHA sites with clinically meaningful access delays indicated that increasing the number of licensed independent practitioners was critical or very important to increasing access.⁵³

The Commission Recommends That . . .

- VHA increase the efficiency and effectiveness of providers and other health professionals and support staff by adopting policies to allow them to make full use of their skills.
- Congress relieve VHA of bed closure reporting requirements under the Millennium Act.
- VHA continue to hire clinical managers and move forward on initiatives to increase the supply of medical support assistants.

At the same time, ineffective use of providers and other health professionals contributes to suboptimal productivity. Highly trained clinical personnel are often unable to perform at the top of their license, meaning they spend much of their time performing tasks that should be done by support staff.⁵⁴ For example, doctors and nurses often escort patients; clean examination rooms; take vital signs; schedule; document care; and place the orders for consultations, prescriptions, or other necessary care that could be done more cost effectively by support staff. Twenty-three percent of VHA providers identified “not working to top of provider licensure” as a barrier in health care provision.⁵⁵

VHA is also currently failing to optimize use of advanced practice registered nurses (APRNs). APRNs are clinicians with advanced degrees who provide primary, acute, and specialty health care services.

Background

A large part of the VHA’s problem with inadequate clinical support staff derives from its difficulties in hiring, retaining, and training medical support assistants (MSAs). These individuals answer phones, schedule care, and verify health care eligibility, among other duties.

⁵³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 95, accessed June 3, 2016,

http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁵⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, ix, accessed June 3, 2016,

http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁵ *Ibid.*, 95.

COMMISSION ON CARE FINAL REPORT

Congress has recently given VHA the flexibility to offer MSAs market-based pay rates.⁵⁶ VHA is changing cumbersome rules that have made hiring new MSAs exceptionally time-consuming.⁵⁷

VHA is working to resolve its problems with resource allocation in clinics. For example, the agency has committed to increasing use of clinical managers to help medical centers better match resources to patient demand. Widely used by other health care systems, clinic managers enhance operations by ensuring that telephone protocols, scheduling, and clinic workflow are operating at peak efficiency. They also ensure that staff members are assigned appropriate caseloads and are meeting productivity standards and wait time targets and that administrative staff has appropriate training in scheduling, coding, and/or documentation.

Many states have already taken the steps to ensure APRNs have full practice authority. VHA is working to do the same, which will allow a vast increase in the number of VHA clinicians available to treat patients independently.⁵⁸

To effectively manage clinician supply for the inpatient setting, administrators require accurate bed count data. Currently in VHA, data integrity of bed counts is compromised as a consequence of disclosure requirements of Congress. VHA is required by statute to complete a complicated reporting, approval, and notification process when it closes hospital beds.⁵⁹ To avoid the reporting requirements some VA medical centers count beds as unavailable indefinitely. This action can skew occupancy rates and thwart planning activities. VHA developed its guidance in part to satisfy the Millennium Act⁶⁰ and other requirements that essentially froze beds at FY 1998 levels.⁶¹

Analysis

VHA has taken a number of measures to address data integrity issues. VHA has started hiring clinical managers to assist in managing resources for effective performance. VHA has made efforts to address problems affecting supply and training of MSAs. Additionally, VHA has recently proposed a rule that would authorize full practice for APRNs working within the agency.⁶²

These measures by themselves, however, will not be sufficient to solve the current problems. VHA must ensure all facilities have enough support positions—both clerical and clinical—to

⁵⁶ Sloan D. Gibson, Deputy Secretary, Department of Veterans Affairs, presentation to Commission on Care, April 18, 2016.

⁵⁷ 38 U.S.C. § 7401(3)(A)(iii).

⁵⁸ Establishing Medication Prescribing Authority for Advanced Practice Nurses, VHA Directive 2008-049, (2008).

⁵⁹ Inpatient Bed Change Program and Procedures, VHA Handbook 1000.01, (2010).

⁶⁰ The Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545, Sec. 301. Title III of the Millennium Act prohibits the secretary from closing in any fiscal year more than 50 percent of the beds within a department medical center unless the secretary first submits to the veterans' committees a justification for such closure and waits to take action on a closure until 21 days after the submission of the report. It also requires the secretary to report annually to the veterans committees on bed closures during the preceding fiscal year.

⁶¹ Extended Care Services, 38 U.S.C. § 1710B(b) requires staffing for extended care to remain at FY 1998 levels.

⁶² "VA Proposes to Grant Full Practice Authority to Advanced Practice Registered Nurses," Department of Veterans Affairs, accessed June 3, 2016, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2793>.

enable all clinicians to work at the top of their licenses and to avoid problems with turnover, unexpected staff absences, and surges in patient demand.⁶³

VHA must have authority to pay competitive rates for the personnel it needs. This goal would be accomplished in part by adopting Recommendation #15 of this report for creating a new personnel system under Title 38 for all VHA employees. Currently, for example, clinical managers and practitioners earn far more in the private sector.⁶⁴

As VHA develops improved clinic management tools such as the Health Operations Dashboard, these tools draw from clinical data, patient data, and other sources to allow managers to make decisions using real-time data.⁶⁵ To be effective tools, the data fed into them must be accurate. Relieving VHA from some of the reporting requirements of the Millennium Act will help accomplish effective use of the dashboard for inpatient management.

Implementation

Legislative Changes

- Create a new alternative personnel system under Title 38 authority as mentioned in Recommendation #15.
- Eliminate bed reporting requirements under the Millennium Bill, and require VHA to report new beds as closed, authorized, operating, staffed, or temporarily inactive within 90 days of enactment.

VA Administrative Changes

- Develop policy to allow full practice authority for APRNs.
- Develop leadership tracks, including clinical and group practice managers, for ambulatory settings.
- Develop training programs for medical support assistants (MSAs).
- Modify policy in VHA Handbook 1000.01, Inpatient Bed Change Program and Procedures, as appropriate.

Other Department and Agency Administrative Changes

- None required.

⁶³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 17-18, accessed June 3 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

⁶⁴ For example, Salaries.com listed a median salary for Clinic Manager III (a manager of a clinic with more than 50 physicians) in Dallas, TX, as \$94,000.⁶⁴ The pay grade assigned for this position is GS-13, which pays about \$73,800 in the first step and increases up to \$96,000. Office of Personnel Management, *Schedule 1 General Schedule*, accessed March 31, 2016, <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/pay-executive-order-2016-adjustments-of-certain-rates-of-pay.pdf>.

⁶⁵ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, presentation to Commission on Care, April 18, 2016.

Recommendation #3: Develop a process for appealing clinical decisions that provides veterans protections at least comparable to those afforded patients under other federally-supported programs.

Problem

All federal providers and most health insurers have processes to ensure that beneficiaries have enforceable protections that allow them to obtain medically necessary care within their health benefits package.⁶⁶ Such processes are imperative, particularly for care plans using capitated payment models for which there are incentives to conserve resources. Most veterans, and even their advocates, are unsure of VHA's process for resolving clinical disputes. This may be because there is not one policy in place for VHA, but 18 (one for each Veteran Integrated Service Network [VISN]).⁶⁷

The Commission Recommends That . . .

- VHA convene an interdisciplinary panel to assist in developing a national revised clinical-appeals process.

As part of the MyVA initiative, the SECVA has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁶⁸ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁶⁹

As part of the MyVA initiative, the SECVA has set a goal of world-class service for veterans, including a proactive patient advocacy team that is integrated into patient-centered care and cultural transformation plans.⁶⁸ The processes in place for patient grievances and central protections to ensure access to medically necessary care remain poorly understood despite these efforts. Also, they may be less comprehensive and fair than appeals processes private health insurers and other federal payers are required to provide.⁶⁹

Background

VHA policy has long required medical centers to operate a patient advocate program to address patient complaints.⁷⁰ In 1996, Congress enacted an eligibility reform statute that, for the first time, gave enrolled veterans access to a uniform benefits package.⁷¹ In implementing that law, VHA conducted a systemwide review of how clinical disputes were handled and consequently instituted an external appeal system in FY 2000. The policy, as outlined in a subsequent directive, allowed VISNs to request external professional boards to conduct impartial reviews of clinical determinations.⁷² That directive also addressed a process for internal clinical appeals. It stated as policy that patients or their representatives who have disputes regarding clinical determinations or services pertaining to provision or denial of care that are not resolved at the facility level must have access to a fair and impartial review of those disputes that could result in a different and/or improved clinical outcome. That policy requires VISN directors to have written policy and procedures in place for how internal appeals are to be handled. Under this policy, VISNs still have authority to request an external review at any time during the clinical

⁶⁶ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

⁶⁷ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁶⁸ "About the VHA Patient Advocate and Veteran Experience Program (VHA PA & VEP)," accessed from VA Intranet, May 31, 2016, <http://vaww.infoshare.va.gov/sites/OPCC/VEP/SitePages/vep-about.aspx>.

⁶⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>. VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷⁰ VHA Clinical Appeals, VHA Directive 2006-057 (2006).

⁷¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁷² VHA Clinical Appeals, VHA Directive 2006-057 (2006).

appeals process.⁷³ Although the directive itself expired in 2011, it continues to serve as guidance because it has not been renewed or replaced.

VHA policy directs that all facilities have a patient advocate office to manage and attempt to resolve complaints. That office, which can serve as the liaison between patients and clinicians, is generally the first stop for veterans who are dissatisfied with a clinical decision.⁷⁴ If a clinical issue is not resolved at the point of the service, it generally goes to the facility director, who is to provide veterans written notification of the facility's decision and inform veterans about the VISN's appeals process. Under the same policy directive, veterans may appeal the facility decision to the VISN director. That official, or a clinical review panel that he or she establishes, is to render a decision within 30 days (or 45 days if the director requests an external clinical review).⁷⁵ Should the VISN director agree with the facility, he or she must notify the veteran that the decision is final or may refer the matter to a VACO office to arrange for an external review.⁷⁶

The VHA process does not appear fully comparable to procedures required under other federal and federally-supported health care programs. For example, under the Affordable Care Act, health care plans are required to provide external reviews to beneficiaries whose internal appeals have been denied.⁷⁷ Unlike those and other appeals processes, veterans have no right to external review; such review is at the discretion of the VISN director. Medicare has an extensive review process for clinical disputes between its managed care organizations and beneficiaries. Beneficiaries have the right to an internal appeal with an option for an expedited review, an internal reconsideration of the initial review, an independent review, a hearing with an administrative law judge, a review by the Medicare Appeals Council and, finally, a federal district court review.⁷⁸ Medicaid has requirements for localities to review appeals from its beneficiaries and for states to offer timely access to fair hearings to determine whether managed care organizations have denied or terminated medically necessary care.⁷⁹ Although VHA's timeframe for decision making seems reasonable, the national policy makes no provision for an expedited review, unlike Medicare managed care organizations and plans providing health benefits to federal employees. VHA's policy is also silent on meeting with veterans to hear their cases much less hold hearings during any point of the appeal. Unlike Medicaid, VHA also lacks any provision for service-continuity while the matter is being appealed. The Commission recommends that VHA develop a revised clinical-appeals process that provides veterans protections at least comparable to those afforded patients under other federal and federally-supported programs, including, at a minimum, a right to an external review at the veteran's discretion.

⁷³ Ibid.

⁷⁴ VHA Patient Advocacy Program, VHA Handbook 1003.4, (2005).

⁷⁵ VHA Clinical Appeals, VHA Directive 2006-057, (2006).

⁷⁶ Ibid.

⁷⁷ "Appealing Health Plan Decisions," Department of Health & Human Services, accessed June 1, 2016, <http://www.hhs.gov/healthcare/about-the-law/cancellations-and-appeals/appealing-health-plan-decisions/index.html>.

⁷⁸ Centers for Medicare & Medicaid Services, *Managed Care Appeals Flowchart CY2016*, accessed May 26, 2016, <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Managed-Care-Appeals-Flow-Chart.pdf>.

⁷⁹ MaryBeth Musumeci, *A Guide to the Medicaid Appeals Process*, accessed June 3, 2016, <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8287.pdf>.

COMMISSION ON CARE FINAL REPORT

Implementation***Legislative Changes***

- None required.

VA Administrative Changes

- Convene an interdisciplinary panel to assist in developing a revised clinical-appeals process and policy that includes all care provided within the VHA Care System, to include representation from Patient Care Services, MyVA's Patient Advocates and Veterans Experience Program, the Office of Equity, the National Center for Ethics in Health Care, and the Office of Access and Clinical Administration. VHA should have that panel examine and offer recommendations regarding the following:
 - Each level of review in the clinical-appeals process – from the facility's initial reconsideration to a final decision by the VISN director to assess the fairness and impartiality in those processes compared to Medicare Managed Care and Medicaid appeals processes and private-sector managed care providers' best practices.
 - Whether VHA should establish a uniform national clinical appeals process.
 - The advisability of requiring review panels consisting of individuals such as attorneys, clinicians, case managers, patient advocates, and administrators to review clinical appeals.
 - Whether hearings or judicial reviews are appropriate at any level of the appeals process.
 - Whether resolutions of clinical appeals are equitable for all types of veterans (service-connected or non-service-connected, by racial or ethnic group, by age, or gender).
 - Options for increasing veterans' awareness of the clinical-appeals process.
- Publish the new clinical appeals policy and process for comment and input by veterans, VHA business partners, and other stakeholders.
- Once the new policy is finalized, VHA must train staff on the new process.

Other Department and Agency Administrative Changes

- None required.

Recommendation #4: Adopt a continuous improvement methodology to support VHA transformation, and consolidate best practices and continuous improvement efforts under the Veterans Engineering Resource Center.

Problem

VHA has not effectively empowered its staff to identify problems and make changes to improve the overall quality of care.

Best practices exist in pockets of VHA; however, communication and support for implementation appear to be challenges. Various facilities indicate best practices are in place but seem isolated rather than widely adopted. Facilities often struggle to implement best practices, and information sharing is limited and ad hoc.⁸⁰

VHA has a program of systems engineering—the Veterans Engineering Resource Center (VERC)—that can assist with transformation efforts, but it is not well known throughout VHA and until recently has been underutilized.

The Commission Recommends That . . .

- The Veterans Engineering Resource Center (VERC) be tasked to assist in transformation efforts, particularly in areas such as access and in areas that affect systemwide activities and require substantial change, such as human resources management, contracting, purchasing, and information technology.
- The many idea and innovation portals within VHA be consolidated under VERC.
- A culture to inspire and support continuous improvement of workflow processes be developed and fully funded.
- VHA's reengineering centers be enabled to proactively identify problem areas within the system and offer assistance.

Background

To become a truly veteran-centric care provider, VHA is working to become a learning organization.⁸¹ Learning organizations focus on worker competency rather than on rules compliance. Instead of using results to identify high- and low-performers, VHA will use this information to identify opportunities to intervene with training or other resources to improve employees' performance universally. Employees and patients should benefit from this approach because it values listening and encourages risk taking and innovation.

VA and VHA have adopted the tenets of LEAN Six Sigma as a systemic change approach to move the system forward. This methodology employs a rigorous define, measure, analyze, improve, and control approach to systemic change. LEAN, initially used by manufacturers, has been used successfully by many health care organizations.⁸² The goal of implementing LEAN practices is to eliminate waste, ensuring that any work done adds value. The MyVA plan calls for MyVA districts and the Office of Policy and Planning to ensure the transmission of best practices and the adopting of LEAN throughout the enterprise to provide a more comprehensive view of quality that balances a results-oriented approach with more process-

⁸⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical)*, 14 and A-2 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸¹ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

⁸² MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 12, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

COMMISSION ON CARE FINAL REPORT

oriented practice.⁸³ So far these efforts have been guided by trial and error, rather than directives and adopting a LEAN, process-driven model.⁸⁴ VHA must sustain its commitment to LEAN Six Sigma as a continuous improvement methodology.

VHA will have to use VERC staff and other trained staff members to ensure that principles of LEAN Six Sigma are applied at every level of the system. VERC has the mission to propose, develop, and facilitate innovative solutions to challenges within VHA health care delivery through the integration of systems engineering principles.

With VERC's reach already extending into access to care, health policy, population health, LEAN management, business systems, clinical systems, safety systems, and innovation, all other programs and initiatives become redundant or ancillary. VHA must assess its new system for best practice diffusion to ensure that selected practices are being appropriately scaled. This goal can best be achieved by collapsing all related efforts into VERC.

There are a number of emerging best practices within the health care sector that apply to all aspects of VHA – health care capabilities, staffing, access, supplies, and facilities – and involve the testing, dissemination, and application of procedures or systems that have been shown to improve approaches, processes, or systems.⁸⁵ VHA needs to have the opportunity to fully leverage and build on institutional strengths by implementing best practices.

VHA has recently developed the Diffusion of Excellence Initiative, which is designed to serve as the mechanism for improving practice through a combination of targeted national guidance and nationally-supported local best practice sharing and innovation.⁸⁶ Its organizational structure includes a governance board chaired by the USH, a Diffusion Council, and action teams responsible for implementing promising practices.

VHA also has many business lines charged with disseminating best practices information, including VERC, Systems Redesign SharePoint – Center for Improvement Education, VA Center for Innovation, MyVA – Best Practices in LEAN, MyVA Blog, MyVA Performance Improvement Hub, Knowledge Management System–Improvement in Action (I-ACT), VA Idea House, VA Pulse: Promising Practices Consortium, Evidence-based Synthesis Program (ESP), Quality Enhancement Research Initiative (QUERI), the Annual Conference on the Science of Dissemination and Implementation, and the Diffusion of Excellence Initiative.

Analysis

LEAN Six Sigma offers VHA a methodology to effect change and VERC offers VHA the agents to lead its implementation. VHA must consolidate its transformational tools, including its best

⁸³ MyVA Integrated Plan, Department of Veterans Affairs, July 30, 2015, 21, accessed June 30, 2016, http://www.va.gov/opa/myva/docs/myva_integrated_plan.pdf

⁸⁴ The MITRE Corporation, Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow—Clinical), viii accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁸⁵ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 41, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁸⁶ Sloan D. Gibson, Deputy Secretary for Veterans Affairs, Department of Veterans Affairs, Building on Excellence, 67, presentation to Commission on Care, April 18, 2016.

practice repositories within VERC. The VERC uses a systemic change process to streamline workflow and procedures by eliminating waste and redundancy to ensure that every step in the process adds value. The VERC offers services to VHA health care facilities upon request, but VHA would substantially benefit if the service was authorized to perform outreach to ensure awareness across the VHA Care System.⁸⁷

Until developing the Diffusion of Excellence Initiative, VHA lacked a uniform way to scale and optimize best practices throughout the enterprise. Although the Diffusion Initiative is initially targeting best practices from within VHA, to be successful, a long-term plan should also allow for the adoption of best practices from the private sector and other government sectors (e.g., the Medicare program related to pricing, contracting, privatization, value-based purchasing, management, and oversight). Plans should also allow for adaptation at the local and regional levels to reflect respective differences in provider supply, veteran needs, and marketplace characteristics.⁸⁸

VHA has multiple offices and sites invested in system reengineering, continuous process improvement, and best practices implementation. Repositories of best practices do not get information to the intended person or group that could benefit from the information and are dependent upon VHA employees knowing they exist.⁸⁹

VHA's National Leadership Council has proposed consolidating these best practice repositories under the VERC, which now serves within the Office of Organizational Excellence. Until recently, VERC has been underutilized because it is not known throughout the enterprise.⁹⁰

QUERI is a system that identifies evidence-based care practices that may be scaled for systemwide implementation. QUERI was integrally involved in the transformation of VHA from a largely hospital-based system to one centered on primary care⁹¹ and is now integral to the collaborative endeavor to transform VHA into a learning organization. QUERI recently released a policy brief that indicated veterans' reliance on VHA was strongly correlated to economic factors such as unemployment rates and availability of other health care coverage.⁹²

VA should use a systematic, continuous performance improvement process to improve access to care. Although many VA facilities achieve very high-performance ratings on key access and quality measures, a systematic effort is needed to improve performance. These efforts need to

⁸⁷ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁸⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 28, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf

⁸⁹ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

⁹⁰ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27, accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹¹ "HSR&D Perspectives Blog, QUERI Corner: Surviving and Thriving," Amy Kilbourne, QUERI Program Director, January 20, 2015, accessed from VA Intranet, April 4, 2016, <http://vaww.blog.va.gov/hsrd/category/queri-corner/>.

⁹² Christine Yee, Austin Frakt, and Steven Pizer, U.S. Department of Veterans Affairs, "Economic and Policy Effects on Demand for VA Care," Partnered Evidence-based Policy Resource Center, Policy Brief, March 2016, accessed June 21, 2016, http://www.queri.research.va.gov/partnered_evaluation/YeeFraktPizer.pdf.

COMMISSION ON CARE FINAL REPORT

be embedded into routine use across the VA system. The best solutions should be adjusted to reflect local needs and designed to respond to veterans' preferences, needs, and values.⁹³

A systems approach to health care is “one that applies scientific insights to understand the elements that influence health outcomes, models the relationships between those elements, and alters design, processes, or policies based on the resultant knowledge in order to produce better health at lower cost”⁹⁴ and would benefit VA greatly, especially with resources like VERC to serve as a guide.

Emerging best practices have improved health care access and scheduling in various locations and serve as promising bases for research, validation, and implementation.⁹⁵ A variety of quality improvement organizations are involved in establishing and maintaining standards in health care as well as developing measures for the monitoring and assessment of these standards, including The Centers for Medicare & Medicaid Services, the Joint Commission, the National Committee for Quality Assurance, and the National Quality Forum.⁹⁶

The tools of operations management, industrial engineering, and systems approaches are successful in increasing process gains and efficiencies. In particular, a wide range of industries have employed systems-based engineering approaches to address scheduling issues, among other logistical challenges.⁹⁷

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Consolidate all best practices and continuous improvement portals under VERC to provide a more accessible and comprehensive approach to best practice sharing and adoption.

Other Department and Agency Administrative Changes

- None required.

⁹³ RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, 110 and 297 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

⁹⁴ Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, 27 accessed January 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

⁹⁵ Ibid., 15.

⁹⁶ Ibid., 60.

⁹⁷ Ibid., 27-28.

Health Care Equity

Recommendation #5: Eliminate health care disparities among veterans treated in the VHA Care System by committing adequate personnel and monetary resources to address the causes of the problem and ensuring the VHA Health Equity Action Plan is fully implemented.

Problem

The Office of Health Equity (OHE), tasked with eliminating health disparities by building cultural and military competence within VHA, has not been given the resources or level of authority needed to be successful. Until VHA leadership establishes the elimination of health care disparities as a critical strategic priority and commits the resources required to address this problem, health care disparities will continue to persist among veteran patients.

The Commission Recommends That . . .

- VHA work to eliminate health disparities by establishing health care equity as a strategic priority.
- VHA provide the Office of Health Equity adequate resources and level of authority to successfully build cultural and military competence among all VHA Care System providers and employees.
- VHA ensure that the Health Equity Action Plan is fully implemented with adequate staffing, resources, and support.
- VHA increase the availability, quality, and use of race, ethnicity, and language data to improve the health of minority veterans and other vulnerable veteran populations with strong surveillance systems that monitor trends in health status, patient satisfaction, and quality measures.⁹⁸

A systematic review of VHA in 2015 identified the existence of racial and ethnic health inequalities. Health care disparities exist among veterans and especially among minority and vulnerable veterans.⁹⁹ VHA cannot transform veterans' health care to enhance quality, access, choice, and well-being unless these health care disparities are addressed and eliminated. VHA has a plan for addressing these issues—the Health Equity Action Plan (HEAP)—but it has not been fully implemented.

Background

*It is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone.*¹⁰⁰

Across the nation, health care systems are raising awareness about health care equity, inequality, and disparities.¹⁰¹ The growing incidence of health care disparities and inequities is said to be ascribed to individual and collective cultural indifference on the part of health care

⁹⁸ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

⁹⁹ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016, <http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹⁰⁰ Kathleen G. Sebelius, Secretary, Department of Health and Human Services, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities: A Nation Free of Disparities in Health and Health Care*, accessed March 30, 2016, http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

¹⁰¹ Centers for Disease Control and Prevention, *CDC Health Disparities and Inequalities Report – United States, 2013*, accessed April 5, 2016, <http://www.cdc.gov/mmwr/pdf/other/su6203.pdf>.

COMMISSION ON CARE FINAL REPORT

providers and the health care system as a whole.¹⁰² A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health based on racial or ethnic group, gender, age, sexual orientation, military era, geographic location, religion, socioeconomic status, mental health, cognitive/sensory/physical disability, and other characteristics historically linked to discrimination or exclusion.¹⁰³

The United States is becoming increasingly diverse, with racial and ethnic minorities making up more than 36 percent of the population.¹⁰⁴ Indicators of overall health, such as life expectancy and infant mortality, have improved for most Americans; however, some minorities still face comparatively greater likelihood of preventable disease, death, and disability.¹⁰⁵

Although the country's veteran population is projected to decline from 22 million to 14.5 million by 2040, the percentage of minority veterans will increase from 20 percent to 34 percent during the same period.¹⁰⁶ Currently, African Americans make up 11 percent of the veteran population, and Hispanics, 6 percent.¹⁰⁷

Survey data show that minority veterans use VA health care more than White veterans, as shown below:¹⁰⁸

- African American: 38 percent
- Hispanic: 34 percent
- American Indian/Alaska Native: 38 percent
- White: 32 percent

¹⁰² G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," *JHHS.A* (2011), 146.

¹⁰³ "Office of Health Equity," U.S. Department of Veterans Affairs, accessed June 12, 2016, <http://www.va.gov/HEALTHYQUITY/index.asp>.

¹⁰⁴ "Minority Health and Health Equity – CDC," Centers for Disease Control and Prevention (CDC), accessed March 28, 2016, <http://www.cdc.gov/minorityhealth/index.html>.

¹⁰⁵ *Ibid.*

¹⁰⁶ National Center of Veterans Analysis and Statistics, *Minority Veterans 2011 Report*, May 2013, accessed April 6, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf.

¹⁰⁷ U.S. Census Bureau, *American Community Survey, Public Use Microdata Sample (PUMS)*, 2011. Department of Defense, *Population Representation in the Military Services Fiscal Year 2011 Report*, accessed April 5, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Minority_Veterans_2011.pdf.

¹⁰⁸ Reliance projections here are based on ambulatory care utilization. Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 82, accessed May 19, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

Survey data on racial and ethnic minority veterans' use of VHA health care offer revealing insights on current equity issues:¹⁰⁹

- Fifty-seven percent of African Americans indicated they are more likely to use VA as their primary source of health care as compared to 45 percent of Whites.¹¹⁰
- The percentage of African Americans who reported they use VA for all or most of their care needs is 18 percent higher than the percentage of Whites who do so.¹¹¹
- A higher percentage of Whites assessed their health to be good or excellent than did African Americans.¹¹²

Analysis

VHA Office of Health Equity

VA created the OHE in 2012 to identify health care inequities, understand the cause of them, and bring to clinical practice interventions intended to reduce disparity drivers within VA. OHE partners with other VA offices, federal government offices, and nongovernment institutions with missions aimed at promoting health equity.¹¹³ OHE has substantial stakeholder involvement from minority veterans groups, including the Advisory Committee on Minority Veterans (ACMV), rural veterans groups, women veterans, and the Office of Diversity and Inclusion (ODI).¹¹⁴ A staunch internal partner and stakeholder of OHE, ODI's mission is to foster a diverse workforce and an inclusive work environment. The OHE and ODI missions intersect with ODI's special emphasis programs, intended to engage affinity groups and agencies to raise the awareness of the importance of diversity and demonstrate VA's commitment to a diversity model.¹¹⁵

OHE's foundational work included updated systematic reviews and data analyses that not only revalidated VA's previous findings on health care inequities, but also identified more areas of health care disparity among veterans. For instance, hepatitis C virus (HCV) was noted to have disparate effect on racial/ethnic minority veterans and Vietnam-era veterans. Additionally, OHE convened stakeholders and worked with the Health Equity Coalition to develop the VHA Health Equity Action Plan (HEAP), which aligns with the VHA Strategic Plan Objective 1e: Quality & Equity, which states, "Veterans will receive timely, high quality, personalized, safe effective and equitable health care irrespective of geography, gender, race, age, culture or sexual

¹⁰⁹ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹⁰ Department of Veterans Affairs, *2011 Survey of Veteran Enrollees' Health and Reliance Upon VA*, 85, accessed April 2, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SOE2011/SoE2011_Report.pdf.

¹¹¹ Ibid.

¹¹² Ibid.

¹¹³ Department of Veterans Affairs, Office of Health Equity, *US Department of Veterans Affairs Office of Health Equity Mission and Accomplishments*, accessed March 30, 2016, http://www.va.gov/HEALTHEQUITY/docs/OHE_Mission_and_Accomplishments_November_2015.pdf.

¹¹⁴ "Office of Diversity and Inclusion (ODI)," Department of Veterans Affairs, accessed May 13, 2016, <http://www.diversity.va.gov/>.

¹¹⁵ "Office of Diversity and Inclusion (ODI), Special Emphasis Programs," Department of Veterans Affairs, accessed May 17, 2016, <http://www.diversity.va.gov/programs/default.aspx>.

COMMISSION ON CARE FINAL REPORT

orientation.”¹¹⁶ HEAP aims to address five strategic areas: awareness, leadership, health system and life experience, cultural and linguistic competency, and data that are vital for effectively implementing its mission. HEAP implementation strategies are conceptually modeled after the goals and strategies of the National Partnership for Action to End Health Disparities’ National Stakeholder Strategy for Achieving Health Equity sponsored by the U.S. Department of Health and Human Services.¹¹⁷

Despite OHE’s best efforts, HEAP was not fully implemented because VHA leadership failed to establish it as a strategic priority with adequate staffing, resources, and support, and the departure of the then USH, a champion for health equity. These factors led to the reduction of OHE staffing from 8 to 2 FTEs in FY 2013 and a realignment of OHE to several layers down in the organization. As a result of an FY 2015 budget reduction, OHE continues to operate with a two-person staff.¹¹⁸ The reduced staffing level is inadequate to meet the requirements and mission of the office.

OHE has a broad and challenging mission, particularly given the number of minority veterans who rely on VA health care, the health risks in those populations, and the health care disparities those populations experience.¹¹⁹ OHE faces serious challenges in its efforts to carry out its action plan and to realize its broad and critical mission, challenges intensified by its limited staffing and the downgrade of this office within VHA’s organization structure. These include the following:¹²⁰

- lack of quality data on vulnerable populations and disparate health outcomes
- health equity projects that have been delayed or halted due to staff and resource limitations
- lack of data on the overall impact of existing health equity initiatives at facilities
- lack of common definitions on vulnerable populations and health equity concepts

Notwithstanding its limited staffing, OHE has compiled a substantial record of accomplishments. Among its initiatives, OHE embarked in 2015 on a strategy of working collaboratively with the Quality Enhancement Research Initiative (QUERI) to advance health equity. The two collaborative efforts focus on using a population health approach to examine the distribution of diagnosed health conditions, mortality, and health care quality across the VA health care system. A fully staffed OHE would have the capability of creating additional

¹¹⁶ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

¹¹⁷ “National Partnership For Action (NPA), National Stakeholder Strategy for Achieving Health Equity,” U.S. Department of Health & Human Services, accessed May 16, 2016, <http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286>

¹¹⁸ Uche S. Uchendu, Executive Director, OHE, briefing to Commission on Care, December 14, 2015.

¹¹⁹ “Management Brief no. 99,” Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=eBrief-no99. Somnath Saha et al., “Racial and Ethnic Disparities in the VA Health Care System: A Systematic Review,” *Journal of General Internal Medicine*, 23, no. 5, (2008): 654-671.

¹²⁰ Uche S. Uchendu, Executive Director, Office of Health Equity, briefing to Commission on Care, December 14, 2015.

analytical tools to manage the daily health care equity program and provide needed services to advance health equity.¹²¹

Health Care Disparities Among Minority Veterans

Minority groups are at increased risk of major, life-threatening health conditions, as documented in a substantial body of research¹²² and illustrated in the table below:¹²³

Table 3. Major Health Conditions in Racial/Ethnic Minority Groups

Major Health Conditions Identified and Examined in Racial/Ethnic Minority Groups		
African Americans	Hispanics	American Indian or Alaska Natives
<ul style="list-style-type: none"> ▪ Colon Cancer ▪ HIV ▪ Chronic Kidney Disease ▪ Diabetes ▪ Stroke ▪ Venous Thromboembolism (VTE) ▪ Cancer ▪ Heart Disease 	<ul style="list-style-type: none"> ▪ Hepatitis C ▪ Cancer ▪ Heart disease 	<ul style="list-style-type: none"> ▪ Major Non-cardiac Surgery ▪ Pregnant Women with PTSD

HCV is more prominent among some racial and ethnic minority veterans and they are less likely to receive treatment for HCV. In VHA, some racial and ethnic minorities diagnosed with HCV are disproportionately more at risk for having associated liver disease (ALD). Disparities among veterans in the incidence of HCV, illustrated in the graphs below, show the important policy and resource implications for VA.¹²⁴

¹²¹ Ibid.

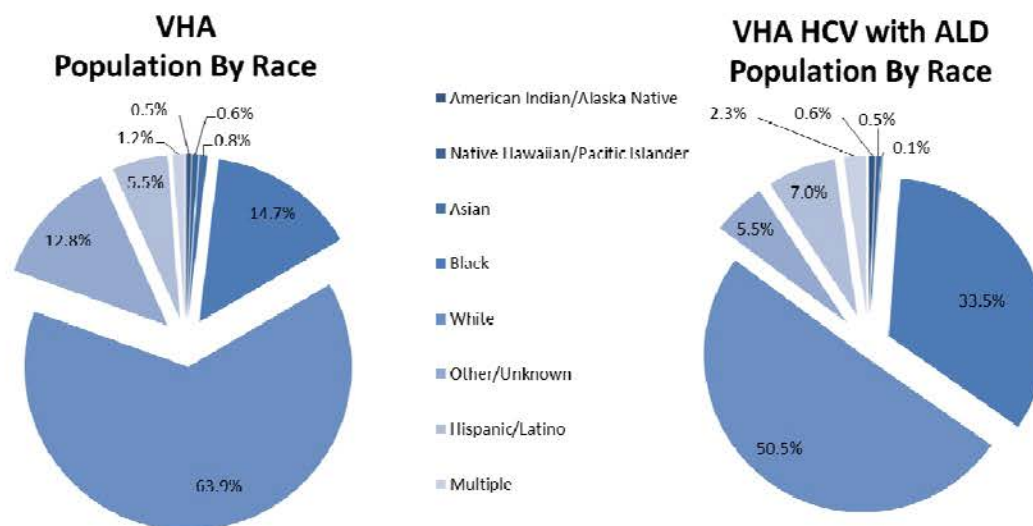
¹²² Andy I. Choi et al., “White/Black Racial Differences in Risk of End-Stage Renal Disease and Death,” *The American Journal of Medicine*, 122, no. 7, (2009): 672-678. Andy I. Choi et al., “Racial Differences in End-Stage Renal Disease Rates in HIV Infection with Diabetes,” *Journal of the American Society of Nephrology*, 18, no. 11 (2007): 2968-2974. Hashem B. El-Serag et al., “Racial Differences in the Progression to Cirrhosis and Hepatocellular Carcinoma in HCV-Infected Veterans,” *The American Journal of Gastroenterology*, 109, no. 9, (2014): 1427-1435. Cleo A. Samuel et al., “Racial Disparities in Cancer Care in the Veterans Affairs Health Care System and the Role of Site of Care,” *American Journal of Public Health*, 104, Supplement 4, (2014): S562-571.

¹²³ Department of Veterans Affairs, *Evidence Brief: Update on Prevalence of and Interventions to Reduce Racial and Ethnic Disparities within the VA*, accessed May 19, 2016, <http://www.hsrd.research.va.gov/publications/esp/HealthDisparities.pdf>.

¹²⁴ Department of Veterans Affairs, Office of Health Equity, *Hepatitis C Factsheet, Hepatitis C, Advanced Liver Disease & Health Care Disparities*, accessed May 25, 2016, <https://github.com/departement-of-veterans-affairs/VHA-Asset/raw/master/Hep%20C%20FACT%20SHEET%20FINAL%2010162015.pdf>.

COMMISSION ON CARE FINAL REPORT

Figure 2. Disparities Among Veterans in the Incidence of Hepatitis C Virus



A recent review of evidence related to racial and ethnic differences in outcomes for VA patients showed moderate- and low-strength evidence suggestive of gaps in morbidity and mortality outcomes among vulnerable veteran populations with major health conditions. These data, presented in the table below, highlight targets for further research.¹²⁵

Table 4. Comparison of Health Outcomes by Race

Comparison		Worse Health Outcomes For Racial Minority Group Relative to Reference Population (usually White)
Moderate-Strength Evidence		
(based on VA data from the early 2000s)		
African American v. White		Increased end-stage renal disease among chronic kidney disease patients
		Increased end-stage renal disease among HIV patients (with or without diabetes)
		Decreased colon cancer survival 3 years after diagnosis
Hispanic v. White		Increased cirrhosis and hepatocellular carcinoma among hepatitis C patients
Low-Strength Evidence		
(each finding supported by only a single retrospective study with important methodological limitations)		
African American v. White		Increased mortality among diabetes patients
		Increased risk of preterm birth among PTSD patients
		Increased mortality at 2 years post-hospitalization among stroke patients
		Decreased survival 3 years after diagnosis of rectal cancer
American Indian or Alaskan Native v. White		Increased risk of 30-day post-op mortality after major noncardiac surgery
		Increased risk of preterm birth among PTSD patients
Combined other racial/ethnic minority groups v. African American		Increased injury-related death among alcohol use disorder patients

¹²⁵ "Management Brief no. 99," Department of Veterans Affairs, accessed May 19, 2016, http://www.hsrd.research.va.gov/publications/management_briefs/default.cfm?ManagementBriefsMenu=eBrief-no99.

OHE's focus, health equity, is intended to combat health care disparities, namely, the differences in the preventive, diagnostic, or treatment services offered to veterans with similar health conditions. Health care disparities stem from a combination of complex factors occurring at the level of the health system, provider, and patient.¹²⁶ Health care disparities can result from biological differences among various racial/ethnic groups as well as from social disparities,¹²⁷ also termed social determinants, which stem from such factors as socioeconomic status, discrimination, education levels, housing, transportation, and crime and violence, and are causally linked to subsequent adult disease.¹²⁸ For example, poor-quality housing poses a risk of exposure to many conditions that can contribute to poor health, such as indoor allergens that can lead to and exacerbate asthma, injuries, and exposure to lead and other toxic substances.¹²⁹ Social determinants that drive health disparities among African Americans, Hispanics, American Indians, and Alaska Natives include race/ethnicity; gender; age; geographic location; religion; socio-economic status; sexual orientation; military era; disabilities, including cognitive, sensory, or physical; and other characteristics historically linked to discrimination or exclusion. Positioned in a department that also provides benefits that fall within the social determinants of health, OHE is in a unique position to improve veterans' health.

The Henry Ford Health System (HFHS) is an example of a health system that is committed to health equity and one VHA can emulate as it works to improve health equity. HFHS is a nonprofit, vertically integrated health care organization that serves the primary and specialty health care needs of residents in southeastern Michigan, including Detroit and its surrounding metropolitan area.¹³⁰ HFHS's comprehensive health equity staff has a health care equity campaign with a goal of increasing knowledge, awareness, and opportunities to ensure health care equity is understood and practiced by HFHS providers and other staff, the research community, and the community-at-large.¹³¹ The campaign is also intended to make health care equity a key, measurable aspect of clinical quality.¹³² A similar effort by VHA would create a system for tracking improvement of health equity over time and holding the organization accountable for ongoing efforts in this regard.

The VHA strategic plan for FY 2013–2018 states that veterans will receive timely, high quality, personalized, safe, effective, and *equitable* health care, irrespective of geography, gender, race, age, culture, or sexual orientation.¹³³ Although that statement signals a sensitivity to health equity, the level of funding support for the VHA office with the lead role in promoting health equity and reducing disparity calls into serious question the leadership priority and commitment to that strategic goal. VHA leadership must make health care equity a strategic

¹²⁶ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹²⁷ James H. Price, Molly A. McKinney, and Robert E. Braun, *Social Determinants of Racial/Ethnic Health Disparities in Children and Adolescents*, accessed April 1, 2016, <http://www.sophe.org/Sophe/PDF/Webinars/20120416151902.pdf>.

¹²⁸ Ibid.

¹²⁹ "What Drives Health," Robert Wood Johnson Foundation, Commission to Build a Healthier America, accessed April 1, 2016, <http://www.commissiononhealth.org/WhatDrivesHealth.aspx>.

¹³⁰ Henry Ford Health System, *Healthcare Equity Campaign 2009-2011 Final Report*, accessed April 1, 2016, <http://www.henryford.com/documents/Diversity/Healthcare%20Equity%20Campaign%20Report.pdf>.

¹³¹ Ibid.

¹³² Ibid.

¹³³ Department of Veterans Affairs, *VHA Strategic Plan: FY 2013–2018*, accessed May 17, 2016, http://www.va.gov/health/docs/VHA_STRATEGIC_PLAN_FY2013-2018.pdf.

COMMISSION ON CARE FINAL REPORT

priority by directing and funding the implementation of VHA HEAP nationwide and designating a leader and clinical champions within each VISN and VAMC, as a designated full-time equivalent (FTE), providing OHE budgetary support in FY 2017 and beyond to fully staff the office so that it can successfully achieve its mission and goals, to include providing additional needed funding to support implementation of the VHA HEAP; and ensuring OHE reports to the chief of VHA Care System (CVCS).

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Make health equity a strategic priority by directing the implementation of the VHA HEAP nationwide and designating a leader and health equity clinical champion within each VISN and VAMC for whom part of their respective FTE position descriptions includes focusing on health equity issues.
- Reestablish OHE staffing based on the 2011 VHA Health Care Equality Workgroup recommendations to enable OHE to fulfill VHA's vision to provide appropriate individualized health care to each veteran in a method that eliminates disparate health outcomes and assures health equity. Action required includes, but is not limited to, funding FTE staffing levels commensurate with the scope and size of other federal offices of health equity.
- Reinstate OHE within the office of the CVCS to underscore health equity as a priority and to position the office to champion successfully the advancement of health equity for all veterans.¹³⁴
- Monitor and evaluate the department's success in implementing HEAP.

Other Department and Agency Administrative Changes

- None required.

¹³⁴ Department of Veteran Affairs, Health Equity Coalition Request for VHA Commitment, February 2016. Principal Deputy Under Secretary of Health Memorandum, Health Equity Coalition, March 21, 2013.

Facility and Capital Assets

Recommendation #6: Develop and implement a robust strategy for meeting and managing VHA's facility and capital-asset needs.

Problem

Veterans who turn to VHA to meet their health care needs should expect that its facilities have been designed and equipped to provide state-of-the-art care. As health care continues to move to ever greater use of ambulatory care delivery, VHA not only lacks modern ambulatory health care facilities in many areas, but generally lacks the means to readily finance and acquire space, to realign its facilities as needed, or even to divest itself easily of unneeded buildings. Many of these barriers are statutory in nature, although VA's own internal processes compound its capital asset challenges. Establishing integrated care networks, as proposed in

Recommendation #1 holds the promise of markedly improving veterans' access to care. That promise cannot be realized without transformative changes to VHA's capital

structure. Political resistance doomed previous attempts to better align VHA's capital assets and veterans' needs. It is critical that an objective process be established to streamline and modernize VHA facilities in the context of the build out of the VHA Care System's integrated networks to ensure the ideal balance of facilities within each network. VHA needs as much control as possible to drive the process so that all facility plans are fully integrated with the strategic vision for the VHA Care System.

Background

Most VHA health care centers were designed when care was focused on inpatient hospital treatment. VA acquired some of these facilities nearly a century ago from the Public Health Service; many others were transferred from the War Department shortly after World War II.¹³⁵ The average VHA building is 50 years old – five times older than the average building age of not-for-profit hospital systems in the United States.¹³⁶ Most of its facilities were designed to meet markedly different needs than today's health care facilities. Some were tuberculosis

The Commission Recommends That . . .

- VA leaders streamline and strengthen the facility and capital asset program management and operations.
- The VHA Care System governing board be responsible for oversight of facility and capital asset management.
- Congress provide VHA greater budgetary flexibility to meet its facility and capital asset needs and greater statutory authority to divest itself of unneeded buildings.
- Congress enact legislation to establish a VHA facility and capital asset realignment process based on the DoD Base Realignment and Closure Commission process to be implemented as soon as practicable. The Commission recommends that the VHA Care System governing board subsequently make facility decisions in alignment with system needs.
- New capital be focused on ambulatory care development to reflect health care trends.
- VHA move forward immediately with repurposing or selling facilities that have already been identified as being in need of closing.

¹³⁵ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, vi, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

COMMISSION ON CARE FINAL REPORT

sanatoriums, others for years primarily housed patients with mental health conditions.¹³⁷ Although many have been extensively renovated, the renovations themselves are now outdated, and the condition of buildings shows this strain. Independent assessments of infrastructure and facilities showed that VHA facilities average a *C minus* score,¹³⁸ meaning much of the total facilities portfolio is nearing the end of its useful life, and 70 percent of facility correction repairs are being made on Grade D facilities.¹³⁹

During the past 8 years, veteran inpatient bed days of care have declined nearly 10 percent as outpatient clinic workload has increased more than 40 percent.¹⁴⁰ Current facilities, whether they have been maintained adequately or not, often do not support contemporary ambulatory care needs, with outpatient care often housed in converted inpatient spaces.

Through its capital planning methodology, VA has identified more than \$51 billion in total capital needs during the next 10 years.¹⁴¹ Capital funding during the past 4 years has averaged just \$2 billion annually.¹⁴² If funding levels remain consistent during the next 10 years, anticipated funding would be \$25 billion to \$35 billion less than the \$51 billion capital requirement.¹⁴³ VA planning must also take account of demographic changes and population migration that have led to underutilized medical centers in some areas of the country, and a need for new capacity in others.¹⁴⁴

Analysis

New Planning Paradigm

As the department acknowledged, “VA’s health care delivery model must . . . change.”¹⁴⁵ Importantly, it recognizes that “No organization can excel at every capability,” and stated “[s]ervice delivery systems designed around core competencies . . . provide the highest potential value to their customers.”¹⁴⁶ The acknowledgement that VHA can best serve veterans by focusing on its core competencies and unique capabilities, while relying more heavily on purchased care holds important implications for VHA’s capital needs and capital asset management. Rather than assessing VHA’s capital needs by reference to an expectation that each VA medical center, or constellation of medical centers, must provide virtually all needed hospital and medical services, capital needs must be redefined within the framework of the VHA Care System’s high-performing integrated community health care networks. VHA must determine what services it will continue to provide directly in a given community before it can determine its respective infrastructure needs. In identifying its core competencies, unique

¹³⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

¹³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 27, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹³⁹ *Ibid.*

¹⁴⁰ *Ibid.*, 46.

¹⁴¹ *Ibid.*, 17.

¹⁴² *Ibid.*, 18.

¹⁴³ *Ibid.*, 18.

¹⁴⁴ *Ibid.*, 59-61.

¹⁴⁵ Department of Veterans Affairs, *Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care*, 18, accessed January 13, 2016, http://www.va.gov/opa/publications/VA_Community_Care_Report_11_03_2015.pdf.

¹⁴⁶ *Ibid.*

capabilities, and needed ancillary services, VHA would be setting at least a general framework through which network and local planners could assess where and how needed services would be delivered, including which would be provided directly by VHA and which through purchased care. Such a mapping exercise would be a first step in developing the integrated community health care networks.

The shape of an integrated delivery network will take different forms in each service-area, and planning and developing those local networks will necessarily require assessing VHA's physical plant and capacity in a new light. That reassessment process would inform capital planning, and must take account of at least three distinct needs: capital needs associated with buildings VA would retain; meeting new or replacement space needs; and the disposal of unused, unneeded property.

Property Divestiture

VHA's principal mission is to provide health care to veterans, yet over time it has acquired an ancillary mission: caretaker of an extensive portfolio of vacant buildings. As recently as October 2015, VA reported that its inventory includes 336 buildings that are vacant or less than 50 percent occupied, requiring it to expend patient-care funds to maintain more than 10,500,000 square feet of unneeded space.¹⁴⁷ The SECVA recently testified that it costs VA an estimated \$26 million annually to maintain and operate vacant and underutilized buildings.¹⁴⁸

VA's authority to carry out property-management is circumscribed in law,¹⁴⁹ and the department at times faces insurmountable challenges in either attempting to repurpose or divest itself of underutilized or vacant property.¹⁵⁰ In contrast to more rigid property-divestiture provisions, VA has had success in using a flexible authority to enter into long-term leases of VA property for *enhanced use*.¹⁵¹ This authority allows VA to lease underutilized capital

¹⁴⁷ Ibid., 92.

¹⁴⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

¹⁴⁹ Authority for Transfer of Real Property; Department of Veterans Affairs Capital Asset Fund, 38 U.S.C. § 8118 Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122. For example, under section 8118, VA must receive at least full market value in transferring property, unless the property is transferred to an entity that provides services to homeless veterans, and any proposed transfer is subject to the requirement in section 8122 that VA first hold hearings, notify Congress in advance, and not proceed for a specified period. VA property can be determined to be "excess," though under 38 U.S.C. § 8122(d)(1), VA may not make such a declaration unless the property is not suitable for use for provision of services to homeless veterans and reviewed for possible disposal under the Property Act Disposal, administered by the General Services Administration (GSA) (40 U.S.C., subchapter III). GSA employs a rigorous, multistep process to assure that the asset is not needed by any other Federal agency. Under the Act, the agency disposing of the asset is responsible for funding disposal costs, including environmental remediation. GAO has testified that properties remain in an agency's possession for years and continue to accumulate maintenance and operations costs because of the legal requirements agencies must meet and the length of the process. (U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>).

¹⁵⁰ With many properties under the protection of the National Historic Preservation Act (16 U.S.C. § 470h-3), VA faces obstacles and delays in efforts to divest itself of these properties; VACO staff report that stakeholder concerns have been obstacles.

¹⁵¹ Enhanced-Use Leases of Real Property, 38 U.S.C. §§ 8161-8169, as amended by Veterans Millennium Health Care and Benefits Act, Section 208, Pub. L. No. 106-117, 113 Stat. 1545 (1999), as in effect when GAO testified on this successful program (U.S. Government Accountability Office, *VA Real Property: VA Emphasizes Enhanced-Use Leases to*

COMMISSION ON CARE FINAL REPORT

assets to private-sector entities for up to 75 years to develop housing for homeless and at-risk veterans and their families. Most recently, however, Congress imposed severe limits on that leasing authority.¹⁵²

Ongoing Capital Needs

Establishing a transformative new health care delivery model that relies more on purchased care will not eliminate the need for new clinics, facility renovations, and remedying VHA space deficiencies. The scope of those needs must still be determined in light of a proposed new delivery system, but they cannot be ignored. The *Independent Assessment Report* catalogued the challenges of managing and operating VA's capital program and the need to deploy best practices to improve total performance, and clearly address the importance of more modern facilities for delivering high quality care.¹⁵³

Of particular concern is an apparent breakdown in the process of bringing new clinics online and renewing the leases of existing clinics. With current law requiring congressional approval of any lease with an average annual rental of more than \$1 million,¹⁵⁴ a Congressional Budget Office (CBO) ruling¹⁵⁵ has upended the approval process and halted the leasing program.¹⁵⁶ Indicative of the scope of the problem, VHA's then USH testified in 2013 that VA, since 2008, had opened 180 leased medical facilities, 50 of which required authorization as major leases.¹⁵⁷ Currently, 24 major VA leases are in limbo.¹⁵⁸

Manage its Real Property Portfolio, GAO-09-776T (Washington, DC, 2009), <http://www.gao.gov/assets/130/122697.pdf>. For example, VA has authority to outlease its facilities for up to 3 years, but may not retain the proceeds of any such leasing (Authority to Procure and Dispose of Property and to Negotiate for Common Services, 38 U.S.C. § 8122(a)(1)). U.S. Government Accountability Office, *Federal Real Property: Progress Made on Planning and Data, but Unneeded Owned and Leased Facilities Remain*, GAO-11-520T (Washington, DC, 2011), 5, <http://www.gao.gov/products/GAO-11-520T>.

¹⁵² Before the sunset of that authority in 2011, VA could enter into such a long-term lease if (1) at least part of the property's use would contribute to VA's mission, (2) the lease would not be inconsistent with that mission; and (3) the lease would enhance the use of the property (Enhanced-Use Leases, 38 U.S.C. § 8162(a)(2)). Congress reauthorized enhanced-use leasing, but limited it to a single use: the development of supportive-housing for veterans who are homeless or at risk of homelessness (Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Sec. 211, Pub. L. No. 112-154, 126 Stat. 1165 (2012)).

¹⁵³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁵⁴ Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104.

¹⁵⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 42 (June 27, 2013) (Statement of Robert A. Sunshine, Deputy Director, Congressional Budget Office), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁶ *Ibid.* CBO maintains that the structure of VHA's lease transactions—the lease of a facility, designed by and built for VHA, and for which payments retire most or all of the debt over the life of the lease—is in the nature of a governmental purchase, and, as such, the full cost of acquiring the facility should be budgeted up front, rather than spread over the duration of the lease. As budget rules generally require that Congress offset that aggregate cost, CBO's position has had the effect of blocking what had previously been a manageable funding process.

¹⁵⁷ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., 44 (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

¹⁵⁸ "Witness Testimony of Honorable Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, Hearing on 2/10/2016: U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2017," House Committee on Veterans' Affairs, accessed June 20, 2016, <https://veterans.house.gov/witness-testimony/the-honorable-robert-a-mcdonald-2>.

One of the primary benefits of leasing is that it can provide flexibility and speed.¹⁵⁹ But the time VHA has required to execute a lease, from planning through to activation, has taken almost 9 years in the case of a major lease,¹⁶⁰ in contrast with private-sector expectations of build-to-suit leases that often take fewer than 3 years.¹⁶¹

In acknowledging the magnitude of the challenges associated with VA's capital program and the budget constraints within which VA is operating, the *Independent Assessment Report* includes a suggestion that transformative options be considered, to include alternative vehicles for capital delivery such as public-private partnerships.¹⁶²

Capital Asset Management

Capital asset management itself requires reengineering. Facilities-related functions are dispersed through VA, resulting in a lack of accountability for outcomes, a mismatch between planning efforts and funding decisions, and separation of project execution and facilities management,¹⁶³ suggesting a need for transformative changes in operations.¹⁶⁴

In its work to foster transformation, department officials have recognized many organizational and process challenges that require priority attention, including the need to realign its infrastructure, identify new (private) sources of financing, streamline investment decision making and contracting, and improve the management of capital projects.¹⁶⁵ Organizational change aimed at streamlining and better aligning core processes is vital to effective operation of VA's facilities programs.

Capital-Asset Imperatives

The planning and development of a new delivery model centered on establishing integrated networks of care has major implications for identifying, planning for, and realizing VHA's capital needs. Greater reliance on community care, inherent in that model, establishes a new set of imperatives, specifically, a need for

- facility realignment
- more effective means of repurposing or other divestiture of unneeded buildings and land
- new, more effective tools to meet VHA's need for new clinic capacity and major construction
- more effective management of VHA's capital needs

¹⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 159, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁶⁰ Ibid., 159-160.

¹⁶¹ Ibid., 160.

¹⁶² Ibid., vii-ix, 34.

¹⁶³ Ibid., vi, 20.

¹⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, K-5, accessed June 2, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁶⁵ Interviews of VA staff by Commission on Care staff, April 2016.

COMMISSION ON CARE FINAL REPORT

Facility Realignment

VA planning must closely examine the role of, and future for, individual facilities, in light of a transformative new delivery model. For more than a quarter century, VHA leaders have cited the need for medical center mission changes, realignments, disposal of unneeded buildings, and where indicated, hospital closures.¹⁶⁶ The critical importance of transforming VA health care delivery gives new urgency to providing tools to realign VHA's care-delivery infrastructure. The Commission recognizes that the SECVA does have authority to "consolidate, eliminate, abolish, or redistribute the functions of . . . [VA] facilities, and to carry out an administrative reorganization" of a field facility.¹⁶⁷ But that authority may generally not be unilaterally exercised.¹⁶⁸ In addition, despite VA's having established two previous commissions to address the need for facility realignment, leaders have had only limited success in achieving that objective. The exercise of SECVA's broad authority to reorganize is tempered by the prerogatives and fiscal authority held by Congress. Congress has rejected legislation that proposed a process to reassess the future of individual VA facilities,¹⁶⁹ reflecting concerns over veterans losing access to care and the potential of constituents losing employment. Such concerns can be addressed. To be successful, a capital asset realignment process must be conducted on a systemwide basis within a framework that provides for sound planning; the exercise of objective, independent expertise; and a reliable mechanism for implementation. Congress can look to and adapt a proven model¹⁷⁰—the military base realignment and closure (BRAC) process—to meet those objectives and achieve marked improvements in access to care.

Congress should enact legislation, based on DoD's BRAC model, to establish a VHA capital asset realignment process to more effectively align VHA facilities and improve veteran's access to care. Creating a robust capital asset realignment process is vital because previous capital divestiture efforts have failed.¹⁷¹ This process should offer a level of rigor far beyond what currently exists for repurposing and selling capital assets. It should require VHA to employ criteria set by the VHA Care System governing board (see Recommendation #9) to conduct locally-based analyses of capital assets, based on national process criteria. Information generated would be used to assist an independent commission, established under the

¹⁶⁶ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

¹⁶⁷ Authority to Reorganize Offices, 38 U.S.C. § 510.

¹⁶⁸ Authority to Reorganize Offices, 38 U.S.C. § 510(c). In instances where a reorganization would reduce employment by 15 percent or more at a facility, VA must provide Congress a detailed plan and justification, and must defer implementation for at least 45 days.

¹⁶⁹ Veterans Millennium Health Care and Benefits Act, H.R. 2116, 106th Cong. (1999). Section 107 of House-passed H.R. 2116 would have established a mechanism for VA to cease providing hospital care at medical centers which were no longer providing high quality, efficient hospital care because of factors such as aging physical plant, functional obsolescence, and low utilization, and to redirect funds instead toward establishment of enhanced-service programs. In taking up H.R. 2116, the Senate did not adopt that provision, and it was not included in the Veterans Millennium Health Care and Benefits Act, Pub. L. No. 106-117, 113 Stat. 1545 (1999), accessed January 12, 2016, <https://www.gpo.gov/fdsys/pkg/PLAW-106publ117/html/PLAW-106publ117.htm>

¹⁷⁰ Defense Base Closure and Realignment Commission, *Defense Base Closure and Realignment Act of 1990 (as amended through FY 05 Authorization Act)*, accessed June 23, 2016, <http://www.brac.gov/docs/BRAC05Legislation.pdf>.

¹⁷¹ "VA Chief Seeks Panel to Revamp System," Christopher Scanlan, *Philly.com*, accessed December 31, 2015, http://articles.philly.com/1989-07-18/news/26134051_1_va-hospitals-derwinski-veterans-hospital. "Distinguished Group Selected for CARES Commission," Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, March 3, 2003, accessed December 31, 2015, <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=578>.

legislation, in making recommendations regarding realignment and capital asset needs.¹⁷² The independent commission would conduct a thorough, one-time process, to include making site visits and holding hearings to inform recommendations that would constitute a proposed national realignment plan. The VHA Care System governing board would review, and adopt or make recommendations to revise, the independent commission's recommended realignment plan. The commission would then empower the VHA Care System governing board to implement the recommendations unless, within a specified timeframe, Congress disapproves the entire plan on an up or down vote. The Commission on Care envisions that after the completion of a realignment carried out under such proposed legislation and in the course of ongoing VHA transformation, the VHA Care System governing board would make all additional facility alignment decisions, to meet veterans' needs and to fully integrate with the strategic vision for the VHA Care System.

Repurposing and Divestiture of Unneeded Buildings and Land

Maintaining health care facilities to provide state-of-the-art care requires ongoing financial support. Bearing the additional cost of maintaining outdated, vacant, and unused buildings diminishes operating funds needed for patient care, and yields no benefit. Even taking unused buildings offline and placing them in *mothball status*, requires tens of millions of dollars in basic building maintenance.¹⁷³ If VA could sell, repurpose, or otherwise divest itself of unused or underutilized buildings in a timely, cost-effective manner, it would free funds for the purposes for which they are appropriated.¹⁷⁴

Enhanced-use leasing authority has in the past provided VHA a viable tool that prevents the need for such unnecessary spending, while permitting development of vacant property for uses compatible with VHA's mission, and effective use of the proceeds, whether in cash or in kind.¹⁷⁵ This leasing mechanism has been put to particularly effective use in leveraging an asset that VHA can no longer use, but which has development potential, as consideration for an asset it may need, such as clinic space. But limiting enhanced-use leasing to a single use that may not be feasible in many locations precludes effective use of a valuable capital-alignment tool.

In many instances, however, the condition or remote location of VHA buildings does not lend itself to enhanced-use leasing. Given the need to dispose of a large inventory of vacant

¹⁷² The process should take into account the community health needs assessments (CHNA) that not-for-profit hospitals are required to carry out under current law, (Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat.119, sec. 9007(a) (2010)) and opportunities to engage community providers in collaborative partnerships. This provision requires tax-exempt hospitals to create a hospital community health needs assessment every three years. This hospital CHNA is developed alongside community stakeholders. The community health needs assessment requirements include: demographic assessment identifying the community the hospital serves; a community health needs assessment survey of perceived healthcare issues; quantitative analysis of actual health care issues; appraisal of current efforts to address the healthcare issues; and formulation of a 3-year plan under which the community comes together to address those remaining issues collectively.

¹⁷³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, 49, accessed June 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

¹⁷⁴ *Ibid.*, B-13.

¹⁷⁵ *Hearing on Assessing VA's Capital Inventory Options to Provide Veterans' Care Before the Committee on Veterans Affairs*, 113th Cong., (June 27, 2013) (Statement of Robert A. Petzel, M.D., Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs), accessed June 20, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-113hhrg82242/html/CHRG-113hhrg82242.htm>.

COMMISSION ON CARE FINAL REPORT

buildings for which there is no realistic prospect of their being repurposed, a streamlined divestiture process is needed.

Meeting Clinic Capacity and Other Infrastructure Needs

Developing a new delivery model and establishing a thorough realignment process may shrink VHA's future capital needs but will not eliminate them. As congressional budget rules have frustrated VHA efforts to lease needed clinic space, it is critical that VHA and Congress find models or remedies to establish new ambulatory care space and renew leases of existing clinics. Congress and VHA should work together to find the means to meet VHA's need for new clinic capacity. Given an impasse in congressional authorization of VA clinic leasing based on build-to-lease contracts, VA should explore the feasibility of restructuring those arrangements. VA should explore an arrangement that remedies the concern that it is entering into capital leases. Such an approach, for which VA provides the builder with space needs rather than a complete design, would have the additional benefit of bringing projects on line much sooner. Absent an effective solution to meeting VA's ongoing need for clinic space, Congress must be willing, as it was in passing VACAA, to take extraordinary steps¹⁷⁶ to overcome a funding challenge, and, in this instance to waive, or suspend for at least 5 years, the operation of current congressional authorization and scorekeeping requirements governing major medical leases.

In addition to severe leasing challenges, current statutory spending limits make it difficult for VHA to modernize and renovate its aging facilities.¹⁷⁷ Notably, minor construction funds, available for "constructing, altering, extending, and improving"¹⁷⁸ any VA facility, are limited to \$10 million,¹⁷⁹ yet such projects may require substantially more given the age and condition of many VA buildings. Congress last lifted the threshold of what constitutes a major medical facility project—the amount above which a project requires specific authorization—more than a decade ago.¹⁸⁰ The Commission believes that with the tight controls a governing board would exercise, that threshold should be lifted substantially, providing needed flexibility to carry out minor construction projects.

As VHA works more closely with community providers and participates in discussions regarding community health needs, it should be open to opportunities to discuss and potentially work toward joint efforts at meeting infrastructure needs.¹⁸¹

¹⁷⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146, 128 stat. 1754, sec. 803 (2014).

¹⁷⁷ VA Office of Inspector General, *Veterans Health Administration: Review of Minor Construction Program*, 8, accessed June 3, 2016, <http://www.va.gov/oig/pubs/VAOIG-12-03346-69.pdf>.

¹⁷⁸ Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242 Div. J., Title II, Department of Veterans Affairs (2015).

¹⁷⁹ A major medical facility project is one involving a total expenditure of more than \$10 million. Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(a)(3)(A).

¹⁸⁰ Sec. 812 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, Pub. L. No. 109-461, 120 Stat. 3403 (2006), raised the threshold as to what constitutes a major medical facility project from more than \$7 million to more than \$10 million.

¹⁸¹ One such public-private model, such as under discussion in Omaha, NE, where talks have centered on private donors' partially funding construction of a replacement medical center, necessarily poses challenges, but merits exploration and support. ("VA Exploring Public-Private Plan for New Facility," Lincoln Journal Star, accessed June 3, 2016, http://journalstar.com/news/state-and-regional/nebraska/va-exploring-public-private-plan-for-new-facility/article_6a90778e-6962-545f-a86a-3f27930bd84e.html.) Although Congress must ultimately provide apt facilities for VA care-delivery, the law has long authorized the SECVA to accept gifts or donations, for purposes of facility

Capital Asset Management

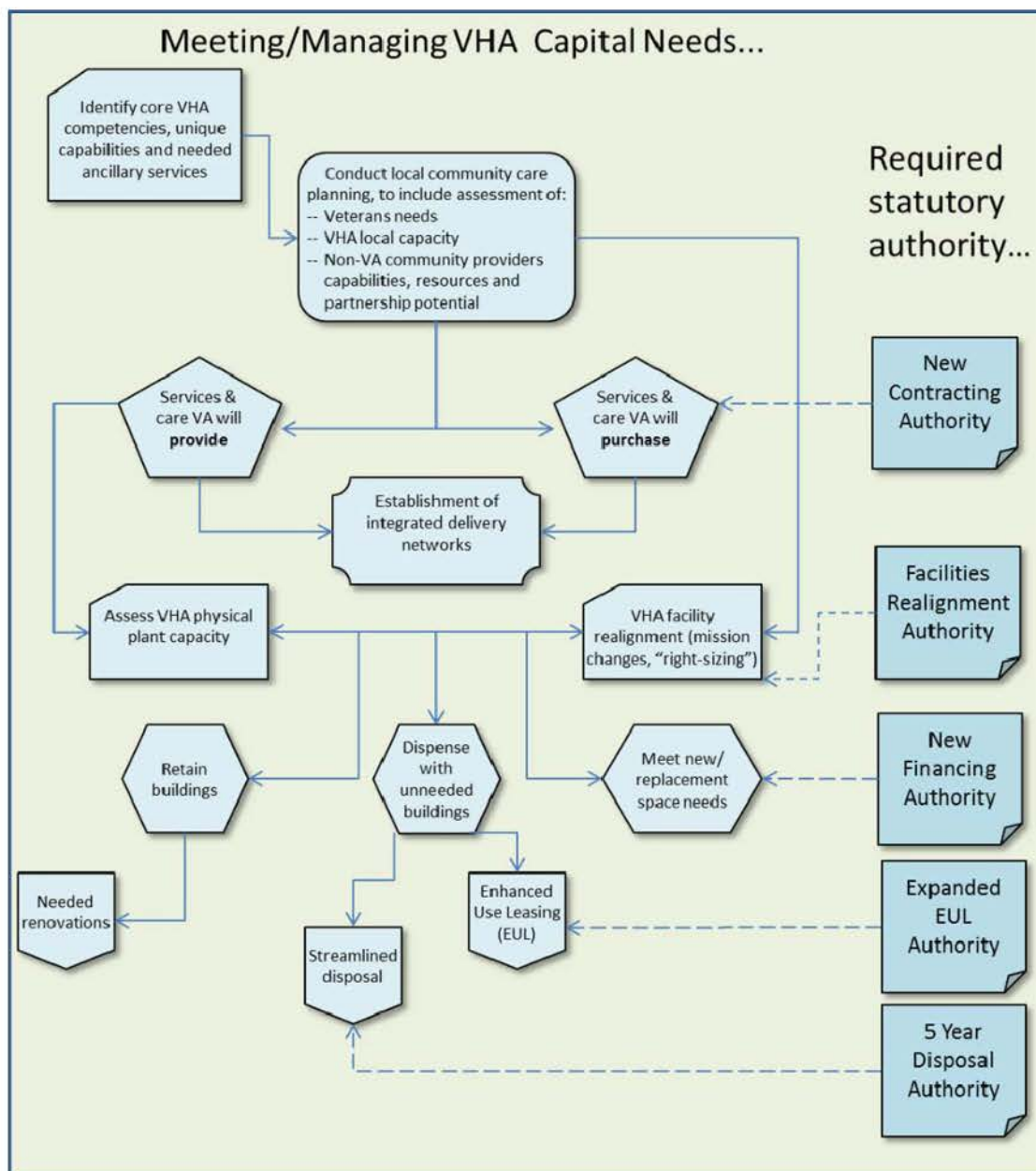
The Commission fully recognizes that VHA has much to do on its own to more effectively meet its capital asset needs. At the core, leaders must strengthen and streamline the capital asset programs' management and operation, to include better aligning the component elements; streamlining the leasing program, contracting, and investment decisions; managing and streamlining project delivery for construction and renovation; and adopting a facility (or building) life-cycle-model planning tool. These are all important elements of needed system transformation.

As depicted in Figure 3, meeting and managing VHA's capital-asset needs require an integrated approach that requires congressional support to tackle the multiple capital-asset challenges facing VHA. The Commission's recommendations for meeting and managing those interrelated capital-asset needs are set forth in the *Implementation* section following Figure 3.

construction. (Congressional Approval of Certain Medical Facility Acquisitions, 38 U.S.C. § 8104(e)) Nevertheless, new legislative authority would almost assuredly be needed to permit development of public-private partnerships that provide new platforms for the construction of new or replacement medical facilities. For example, H.R. 5099 would establish a pilot program permitting VA to enter into public-private partnership agreements to plan, design, and construct new VA facilities using private donations. To Establish a Pilot Program on Partnership Agreements to Construct New Facilities for the Department of Veterans Affairs, H.R. 5099, 114th Cong. (2016), <https://www.congress.gov/bill/114th-congress/house-bill/5099>.

COMMISSION ON CARE FINAL REPORT

Figure 3. The Complicated Process of Meeting and Managing VHA's Capital-Needs

**Implementation****Legislative Changes**

- Provide VA new, more flexible authorities to realign facilities, meet capital-asset needs, and divest itself of unneeded buildings.
- Establishing a VHA capital asset realignment process that provides (notwithstanding any other law) for more effectively aligning VHA facilities with the objective of improving the access, quality, and cost-effectiveness of VA care, and provides for:

- Establishing an independent commission (empowered to hold public hearings, make site visits, and have full access to VHA analyses and data) charged with developing a national capital asset realignment plan that would include recommendations to the VHA Care System governing board (see Recommendation #9) for systemwide facility realignment (to include changes in facility mission, facility downsizing, integration of facilities, and closures), with the rationale for each recommended change.
- The proposed plan would identify (a) the criteria used in developing realignment recommendations, (b) proposals for reinvestment and savings/cost avoidance resulting from the realignment, (c) the projected care improvements that would result, and (d) mechanisms to minimize the adverse effects on displaced employees, to include assuring that, to the extent feasible, VA retrain and reemploys displaced employees.
- The VHA Care System governing board would be empowered to adopt or alter the proposed realignment plan, and to implement the final plan unless, within a specified timeframe, Congress disapproves the plan as a whole on an up-or-down vote.
- Waive or suspend for at least 5 years current authorization and scorekeeping requirements governing major medical facility leases under 38 U.S.C. § 8104.
- Amend 38 U.S.C. § 8104 to lift the threshold of what constitutes a major medical facility project from \$10 million to \$50 million.
- Amend pertinent provisions of 38 U.S.C. § 8161, and what follows, to reinstate and extend for 10 years the authority in prior law (as in effect on December 30, 2011) for VHA to enter into enhanced-use leases for any use that is not incompatible with VA's mission.
- Provide the VHA Care System governing board authority to promulgate regulations that for a period of not more than 5 years, and notwithstanding any other law, would ease the divestiture of unneeded vacant VHA buildings, to include (a) shifting to a third party the cost of meeting environmental requirements, (b) allowing VHA to retain the proceeds of any property sale, and (c) creating a streamlined process to address historic preservation considerations.

VA Administrative Changes

- None required.

Other Department and Agency Administrative Changes

- None required.

Information Technology

Recommendation #7: Modernize VA's IT systems and infrastructure to improve veterans' health and well-being and provide the foundation needed to transform VHA's clinical and business processes.

Problem

To operate a high-performing VHA Care System, VA requires a comprehensive electronic health care information platform that is interoperable with other systems and other health care providers; enables scheduling, billing, claims, and payment; and provides tools that empower veterans to better manage their health. Creating a single, uniform, integrated IT platform will promote care continuity, cost savings, and consistent care delivery and business processes.¹⁸²

VA's antiquated, disjointed clinical and administrative systems cannot support these essential clinical and business processes and consequently are unable to support the Commission's transformation vision for VHA. In addition, currently within VHA, there is no experienced senior health care IT leader focusing on the strategic health care IT needs of veterans and VHA staff.

The Commission Recommends That . . .

- VHA establish a Senior Executive Service (SES)-level position of VHA Care System chief information officer (CIO), selected by and reporting to the chief of VHA Care System (CVCS) with a dotted line to the VA CIO. The VHA CIO is responsible for developing and implementing a comprehensive health IT strategy and developing and managing the health IT budget.
- VHA procure and implement a comprehensive, commercial off-the-shelf (COTS) information technology solution to include clinical, operational and financial systems that can support the transformation of VHA as described in this report.

Background

A fully functional electronic health record (EHR) can improve the quality of patient care, help avert medical errors, and improve communication among providers and with patients.¹⁸³ Starting in the 1970s, VHA became a leader in the development of EHR technology with VistA and a computerized patient record system (CPRS).¹⁸⁴ Full implementation of the EHR, together with other reforms, helped improve the quality of care at VHA.¹⁸⁵ During the last decade, VHA has not been able to maintain an IT advantage.¹⁸⁶ Although in the past most VHA clinicians

¹⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 43-44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁸³ "Does health information technology improve quality of care?" Robert Wood Johnson Foundation, accessed May 20, 2016, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf71333.

¹⁸⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 29-30, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

¹⁸⁵ Phillip Longman, *Best Care Anywhere: Why VA Care Is Better Than Yours* (3rd ed., Berrett-Koehler Publishers, Inc., 2012). Jonathan B. Perlin, Robert M. Kolodner, and Robert H. Roswell, "The Veterans Health Administration: Quality, Value, Accountability, and Information as Transforming Strategies for Patient-Centered Care," *The American Journal of Managed Care* (November 2004), 828-836, accessed June 3, 2016, <http://citescerx.ist.psu.edu/viewdoc/download?doi=10.1.1.476.450&rep=rep1&type=pdf>.

¹⁸⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed April 5, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

have had a high opinion of the clinical applications and databases enabled by VistA and CPRS, a lack of upgrades has put VHA's EHR at risk of becoming obsolete.¹⁸⁷ Many large U.S. health care systems that were early adopters of homegrown EHR systems found themselves in similar circumstances and have since purchased and migrated to commercial off-the-shelf (COTS) products.¹⁸⁸ DoD recently made the same choice.¹⁸⁹

To achieve the Commission's vision of a health care system that delivers quality, access, choice, and veteran well-being, VHA requires effective, robust, and modern information technology systems. A robust EHR system would allow veterans and clinical providers to send, receive, find, and use electronic health information in a manner that is appropriate, secure, timely, and reliable. It would be seamlessly interoperable with other systems including DoD, private-sector providers, and with other VA enterprise systems such as those in the Veterans Benefits Administration (VBA). It would support VHA clinical workflow, evidence-based practice, and patient safety. It would provide clinicians, patients, and administrators the data, analytic power, and user interfaces required to monitor the effectiveness of care and improve it over time. A robust IT system for VHA should include more than just the EHR, however, extending to all the systems and tools required to facilitate and automate business processes that support access and veterans' care. These capabilities include an effective scheduling system, telephone systems, mobile applications, telehealth, financial management systems, human resources systems, and other systems that enable community care.

To realize such a transformation of IT in a system as complex as VHA requires exceptional leadership and staff, sufficient budget, a robust change management plan, effective systems for accountability and quality control, and efficient and agile contracting.¹⁹⁰ Presently, VHA appears to lack a majority of these factors required for success.¹⁹¹

Analysis

Leadership and Staff

Prior to 2006, VHA had a chief health informatics officer responsible for the VHA electronic record system and for coordinating with VA on IT systems. The programmers in VHA worked closely with the clinicians who used the tool to create a system that met their needs.¹⁹² VHA was able to prioritize clinical needs and patient safety requirements within its overall budget and plan for IT spending; however, there was no specific budget line item for the electronic health

¹⁸⁷ Ibid., 29-30.

¹⁸⁸ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

¹⁸⁹ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

¹⁹⁰ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

¹⁹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 41, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

¹⁹² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

COMMISSION ON CARE FINAL REPORT

record system or related technology, and there was limited central oversight or accountability for information technology infrastructure.

VA's IT budget was centralized in 2006, and the Office of Information and Technology (OIT) was assigned to deliver, operate, and manage IT and its budget, across the department. With this change, VHA's needs became only one of the priorities that OIT has had to accommodate and VHA's priorities have not always prevailed.¹⁹³

To ensure that clinical needs and patient safety are a priority, many large health care systems, such as DoD, Cleveland Clinic, Geisinger, and Kaiser Permanente, have a medical CIO (i.e., CMIO) who manages and advocates for the clinical IT needs of the organization. A CMIO ensures that clinicians are involved in the selection of any IT systems they use to perform their job functions and provide patient care, including EHRs. Clinicians involved in the selection and deployment of an IT system are more likely to feel ownership of it and fully adopt its use. The CMIO usually reports to the health system's CEO or CMO, and working in concert with these individuals and the organization's CIO, makes sure that health information needs are prioritized and funded.¹⁹⁴

VA does not have staff with the necessary expertise to execute large-scale IT projects. Previous system implementations have failed because VA did not have individuals with adequate experience to effectively plan and manage system development and deployment. If VA had an adequate system and skilled staff to monitor and identify program and contracting problems affecting the progress of prior IT implementations, effective and timely decisions could have been made to either redirect or terminate VA IT projects that ultimately failed. To avoid repeating these previous IT implementation failures, VA needs to develop effective oversight systems and develop in-house staff with the expertise to oversee, fully support, manage, and execute complex integrated IT programs.¹⁹⁵

Given all of these critical needs, the Commission believes that it is essential for VHA to have a CIO with health care expertise and substantial experience, reporting to the chief of VHA Care System. The VHA CIO will be responsible for managing the complex implementation of a state-of-the-art comprehensive information system platform to support the new integrated VHA Care System, with the functionality, interoperability, and data management capabilities to support the delivery and coordination of high-quality health care for veterans. The CIO will need to work closely with clinical and operational leaders on the effective execution of the new system, and will also need to collaborate with the VA CIO to ensure the integration and coordination of the health care information system and the Veterans Benefit Administration system.

¹⁹³ Ibid., 10.

¹⁹⁴ "CMIOs Help Hospitals Make Tech Transitions," Naseem S. Miller, accessed May 13, 2016, <https://www.acep.org/content.aspx?id=79744>.

¹⁹⁵ Department of Veterans Affairs Office of the Inspector General, *Review of the Awards and Administration of Task Orders Issues by the Department of Veterans Affairs for the Replacement Scheduling Application Development Program*, accessed May 25, 2016, <http://www.va.gov/oig/52/reports/2009/VAOIG-09-01926-207.pdf>.

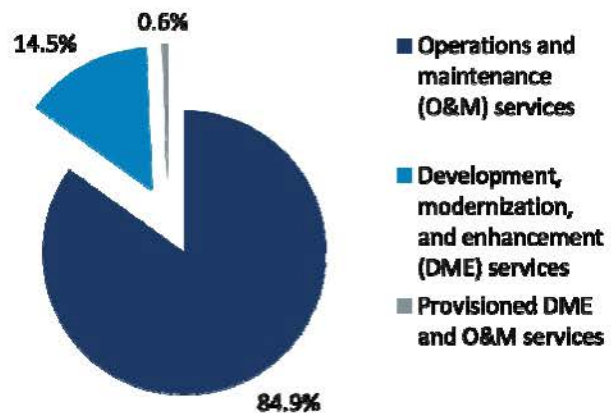
Budget

The 1-year budget appropriations cycle makes it difficult to secure multiyear funding for long-term development and important IT projects.¹⁹⁶ The budget process is disconnected from total lifecycle IT costs.¹⁹⁷ That disconnect has grown wider with a change in law¹⁹⁸ under which Congress provides VHA advanced medical care appropriations—in effect a 2-year budget—while health IT funding remains 1-year money.¹⁹⁹ As the Congressional Research Service (CRS) testified,

providing an advance appropriation for some VHA accounts and funding IT accounts under a regular appropriation act could create a situation whereby, for example, VHA could not purchase computer software although it has procured medical equipment that needs software. Another example would be the difficulty of procuring IT infrastructure to support opening of a new community-based outpatient clinic (CBOC).²⁰⁰

Spending on new systems and upgrades to existing systems now represents only 15 percent of VA's total IT budget (see Figure 4),²⁰¹ meaning that essential upgrades like a new scheduling package and EHR modernization have not had the funding or focus required to succeed. Clinical users have become increasingly frustrated by the lack of any clear advances with VistA during the past decade. Numerous VHA clinicians have experience with commercial EHR systems and want the same level of features, modern clinical capabilities, integration, and mobility they see emerging in the commercial marketplace.²⁰²

Figure 4. VA IT Spending



In July 2015, DoD awarded a \$4.3 billion, 10-year contract to overhaul the Pentagon's electronic health records for millions of active-duty military members and retirees. Officials estimate that

¹⁹⁶ "Coming in 2016: Cloud Legislation," Aisha Chowdhry and Adam Mazmanian, accessed January 12, 2016, <https://fcw.com/articles/2015/12/22/cloud-bill-2016.aspx>.

¹⁹⁷ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

¹⁹⁸ Veterans Health Care Budget Reform and Transparency Act of 2009, Pub. L. No. 111-81, 123 Stat. 2137 (2009).

¹⁹⁹ With the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235 (December 16, 2014), Congress expanded advanced appropriations to additional VA program accounts.

²⁰⁰ U.S. Congress, House of Representatives, Committee on Veterans Affairs, *Funding the U.S. Department of Veterans Affairs of the Future: Hearing before the Committee on Veterans Affairs U.S. House of Representatives*, 111th Congress, 1st Sess., April 29, 2009, 60, accessed June 3, 2016, <https://www.gpo.gov/fdsys/pkg/CHRG-111hhrg49914/pdf/CHRG-111hhrg49914.pdf>.

²⁰¹ Department of Veterans Affairs, *Information Technology Agency Summary*, accessed May 25, 2016, <https://itdashboard.gov/drupal/summary/029>.

²⁰² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, v, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

COMMISSION ON CARE FINAL REPORT

during its potential 18-year life, the contract could be worth just less than \$9 billion.²⁰³ The recent Senate appropriations bill for VA OIT allots \$63 million toward development and modernization of VA's existing EHR (i.e., VistA Evolution).²⁰⁴ Assuming that VA's implementation of a new COTS EHR would be similar in size and scope to DoD's EHR implementation, VA would be short \$3.67 billion in funding for a new COTS EHR, given the current funding amount of \$63 million per year. VA will require a substantial increase in IT funding to support the successful implementation of a new comprehensive COTS EHR.

Robust Change Plan

Because VistA has been customized at each medical center, there are few standard data elements. The varied algorithms lead to a complex, heterogeneous mix of hardware and software that impedes system changes and new capabilities and raises operations and maintenance costs.²⁰⁵ Due to excessive project management overhead, a complex legacy IT infrastructure that is difficult to modernize, and more than 130 variations of the primary software system deployed across VHA medical facilities, the implementation of improved IT capabilities in the last 10 years has been extremely limited.²⁰⁶ VA is currently weighing whether to continue to modernize VistA or purchase a COTS health information technology platform. The Commission recommends moving to a COTS program.

Whether VHA moves forward with the purchase of a COTS product, as recommended by the Commission, or continues attempting to modernize VistA, VHA must effectively manage the change process. At present, a lack of standard clinical documentation has made it harder to develop effective clinical decision-support systems and hinders EHR information exchange among VA Medical Centers (VAMC), between VA and non-VA facilities (including those of DoD), and between VA and individual veterans. Shared data must be well labeled in a way that the receiving system can identify and properly ingest such data. An electronic medical record can contain as many as 100,000 different data fields. The lack of data standards presents challenges to using comparable data for analysis and disparities among the 130 tailored local instances of VistA, complicating information sharing, data aggregation, and analytics.²⁰⁷ VHA has not established comprehensive semantic definitions for data elements through the use of standard nomenclatures, terminologies, and code sets. Doing so is required to ensure consistency and integration across multiple systems, leverage follow-on IT products, and facilitate analytics for clinical decision making.²⁰⁸

The Office of the National Coordinator (ONC) for Health IT, under HHS, is responsible for advancing national connectivity and interoperability of health information technology. The

²⁰³ "Cerner wins \$4.3 billion DoD contract to overhaul electronic health records," Amy Brittain, *The Washington Post*, accessed May 25, 2016, https://www.washingtonpost.com/national/health-science/cerner-wins-dod-contract-to-overhaul-electronic-health-records/2015/07/29/7fbfccfa-35f5-11e5-b673-1df005a0fb28_story.html.

²⁰⁴ S. Rept. 114-237 – Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, 2017, accessed May 25, 2016, <https://www.congress.gov/congressional-report/114th-congress/senate-report/237/1>.

²⁰⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²⁰⁶ *Ibid.*, 41.

²⁰⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, vi, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁰⁸ *Ibid.*, viii.

ONC developed the National Interoperability Roadmap with the goal of being able to use electronic health information exchange, so information can follow a patient where and when it is needed, across organizational, health IT developer, and geographic boundaries. The roadmap lays out a clear path to catalyze the collaboration of stakeholders who are going to build and use the health IT infrastructure.²⁰⁹ VA's intent to expand veteran care to more community providers through the creation of locally-integrated health care networks will mean that it is important for VHA to follow the ONC roadmap and standards. Following this roadmap includes using the continuity of care document to exchange data, which was established by ONC and is followed by community health care providers. VA OIT is currently collaborating with the ONC on VA's plans for interoperability and has committed VA to following the roadmap.²¹⁰

VHA does not yet have a robust, detailed strategy and roadmap for IT initiatives across VHA that integrates veteran access to scheduling via phone, telehealth, and mobile apps.²¹¹ National deployment of the VistA Scheduling Enhancement and the veteran mobile scheduling Veteran Appointment Request app, are initial steps to prepare for the implementation of new COTS electronic medical system with a scheduling package.

To resolve the underlying systemic issues with VistA scheduling, VA awarded a contract for the implementation of VA's new COTS medical appointment scheduling system in August 2015.²¹² This system is a COTS scheduling solution that, when implemented, is expected to move VHA from primarily a face-to-face appointment model to a coherent, resource-based system with broad opportunities for improved services for VA stakeholders.²¹³ Deployment is awaiting the final decision on whether VHA will continue with VistA or purchase a full COTS product.

COTS Solution

The current VistA/computerized patient records systems are based on a tightly integrated, monolithic architecture and design with numerous and diverse functional components and associated interdependencies. These characteristics impose barriers to modernizing the respective systems. In addition, the high cost of infrastructure operation and maintenance (85 percent of the total IT budget) reduces funding available for new development efforts.²¹⁴ Maintenance and data sharing are further complicated because most VAMCs have customized their local versions of VistA, leading to approximately 130 different versions of VistA across the country.²¹⁵

²⁰⁹ "A Shared Nationwide Interoperability Roadmap Version 1.0," HealthIT.gov, accessed March 29, 2016, <https://www.healthit.gov/policy-researchers-implementers/interoperability>.

²¹⁰ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²¹¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 44, accessed April 4, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹² "\$623M Medical Appointment Scheduling System (MASS) Contract," G2Xchange, accessed May 3, 2016, <https://www.g2xchange.com/statics/623m-medical-appointment-scheduling-system-mass-contract>.

²¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 40, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²¹⁴ Ibid., vi.

²¹⁵ Ibid., vi.

COMMISSION ON CARE FINAL REPORT

VHA relies on a VistA scheduling package to provide veterans with access to health care. The system is antiquated, highly inefficient, does not optimally support processes or allow for efficient scheduling of appointments. A report on scheduling published by the Northern Virginia Technology Council (NVTC) in October 2014, showed that VA's exam-scheduling processes are not enabled by state-of-the-art technologies or consistently applied standard operating procedures.²¹⁶ To improve this situation, VHA has developed, and is in the process of a national roll out of, VistA scheduling enhancements, which provides an improved user interface (i.e., graphic user interface or GUI). Although the new GUI will help veterans gain access to care by implementing better scheduling procedures, it does not address the need that managers, planners, and administrators have for accurate and timely data on clinic use.²¹⁷ For instance, VHA's new health care operations dashboard shows that more than 55 percent of clinic slots in VHA go unused each day.²¹⁸ However when questioned about this data, VHA notes that it is not correct.²¹⁹ The underlying VistA scheduling software does not allow accurate representation of clinician time toward each clinic stop. As a result, whether data is presented in a dashboard or a new GUI tool, as long as the underlying data cannot be captured accurately, then VHA will not have the information it needs to effectively manage the supply of clinic slots.²²⁰

VA's financial management information technology system is woefully outdated and VA has previously wasted approximately \$500 million in two failed attempts to replace it. Given VA's lack of an integrated finance and logistics IT system, VA has no method to perform commitment accounting.²²¹ VA's current financial management system does not support streamlining and automation of VA's revenue cycle.²²²

Community care processes currently include eligibility determinations, referrals and authorizations, care coordination, network management, claims, and customer service.²²³ VA's information technology systems limitations often demand manual processes to support community care that can reduce the timeliness and accuracy of data and obscure the true state of VHA's activities. Relying on manual processes slows collections and payment activities and introduces errors and waste into the process.²²⁴ Barriers to automation are multifactorial,

²¹⁶ Ibid., 39-40.

²¹⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²¹⁸ Crystal Wilson, Office of Analytics and Business Intelligence, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²¹⁹ Joe Francis, Director of Clinical Analytics and Reporting, Veterans Health Administration, email to Commission on Care staff, May 3, 2016.

²²⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow—Scheduling)*, 26, accessed May, 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

²²¹ Jan R. Frye, *Letter to Secretary McDonald, March 19, 2015*, accessed May 17, 2016, http://extras.mnginteractive.com/live/media/site36/2015/0522/20150522_025126_WhistleblowerMemo.pdf.

²²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, 24, accessed May 24, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

²²³ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 42, accessed March 28, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

including confusing eligibility rules governing which veterans may receive care outside VHA and for what conditions, in what circumstances, and which services may be billed to third-party insurers.²²⁵ In addition, there are multiple authorities for purchasing community care—all with different business rules²²⁶ and reimbursement rates, as well as antiquated financial management information systems that are not standardized to private-sector processes. All of these impediments are exacerbated by workers throughout the revenue cycle who are poorly compensated and marginally trained, experience high turnover, and work in environments with a continuous 20 percent vacancy rate;²²⁷ thus, they cannot effectively manage certain business practices such as insurance verification and ensuring clinicians complete necessary coding documentation.²²⁸

Many large U.S. health care systems that originally developed in-house EHRs have since purchased and migrated to COTS EHRs.²²⁹ DoD recently made the same choice, deciding to replace its homegrown EHR with a COTS product to take advantage of private-sector innovation and have an EHR that communicates with private-sector systems. For a system in which 60 to 70 percent of military health care takes place outside the DoD,²³⁰ this was an important business consideration that is also consistent with VHA's long term direction. Very large IT programs with purpose-built systems and labor-driven business models are shifting rapidly toward more open source, COTS systems. Large proprietary IT solutions are increasingly being replaced by less risky, agile, and open-source solutions or IT as-a-service models, and getting away from client-server models.²³¹

Interoperability

VHA's EHR issues stymie interoperability among VHA facilities as well as between VHA and DoD and other non-VHA providers. Multiple assessments noted the lack of interoperability resulted in incomplete patient records with potentially substantial implications for veterans and VHA. Incomplete records introduce unnecessary clinical risk, complicate the transition from

²²⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I (Business Processes)*, 19-20, accessed April 26, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁶ Baligh Yehia, MD, ADUSH Community Care, briefing to Commission on Care, April 18 and 19, 2016.

²²⁷ Healthcare Talent Management, Veterans Health Administration, email to Commission on Care, April 11, 2016. Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America's Veterans*, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCTFinalReporttoVA-revised3.pdf>.

²²⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report, Appendix I, Business Processes*, 13-14, accessed November 24, 2015, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²²⁹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

²³⁰ "DoD Awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

²³¹ "\$5 Billion Leidos-Lockheed Deal: Size Still Matters," Frank Konkel, accessed February 4, 2016, http://www.nextgov.com/defense/2016/02/5b-leidos-lockheed-deal-size-still-matters-federal-it-contracting/125617/?oref=nextgov_today_nl.

COMMISSION ON CARE FINAL REPORT

DoD to VHA care, and inhibit VHA's ability to bill and collect revenue in an accurate and timely manner.²³²

As GAO reported in August 2015, VA and DoD have taken initial steps to increase interoperability between their existing electronic health record systems.²³³ They have deployed the Joint Legacy Viewer (JLV), which provides a patient-centric, integrated view of a patient's health data from VA, DoD, and community health partners on one screen. It has been available at all VA medical centers since October 2014 and currently has more than 70,000 users.²³⁴ The JLV is a positive step in supporting coordination of care among VA, DoD, and community partners, but it only allows for providers to view veterans'/service members' medical records and does not yet allow for the other agencies' medical records to be updated by providers.²³⁵

VA's next evolution in interoperability with DoD and community partners is the deployment of their Enterprise Health Management Platform (eHMP). eHMP is intended to provide VA streamlined access to complete patient history from VA, DoD, and community health partners in a single, reliable, customizable, and secure interface that is easy to use. It is reported to deliver a modern, web-based user interface and supporting infrastructure and is intended to replace the Computerized Patient Record System (CPRS) as VA's primary point-of-care application. The national rollout of eHMP is expected to be completed by December 2017.²³⁶

VHA does not have everything that is needed in an IT system to manage the business and clinical aspects of care in the community and support the overall veteran experience in an expanded community network. To address these gaps and provide health care well into the future, VA intends to develop in house a comprehensive and interoperable digital health platform (DHP). The DHP is intended to seamlessly integrate all of VHA's core processes, including scheduling, supply chain management, billing, and claims. Through consolidation of more than 40 contact center systems and more than 130 versions of the VistA EHR and clinical procurement/inventory systems, the DHP is designed to enable VHA's operation as a holistic, platform business and greatly reduce the cost of system maintenance across the IT enterprise.²³⁷

Because there is no unique patient identifier, problems exist with "1) accessing and integrating information from different providers and provider computer systems, 2) aggregating and providing a lifelong view of a patient's information, and 3) supporting population-based research and development."²³⁸ To accurately match veteran patient data that is exchanged between VA and non-VA providers, both organizations need to use the same unique patient

²³² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 44, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

²³³ "Electronic Health Records: VA and DOD Need to Establish Goals and Metrics for Their Interoperability Efforts," U.S. Government Accountability Office, accessed April 1, 2016, <http://www.gao.gov/products/GAO-16-184T>.

²³⁴ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁵ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-35, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²³⁶ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²³⁷ LaVerne H. Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²³⁸ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPAVU-508.pdf>.

identifier. This practice is currently not used.²³⁹ Each health care system uses a unique patient identifier number, but it is specific to that system.²⁴⁰ VA uses patients' social security numbers as unique identifiers; whereas, due to stricter security standards required by HIPPA privacy laws that community providers must adhere to, many non-VA providers use other personally identifiable information (e.g., first name, last name, date of birth, and phone number) to match patient identities between record systems. Studies have shown that patient identification error rates range from 7-20 percent.²⁴¹ For VA to accurately identify patients and their records, a unique national patient identifier is essential.

The security of electronic records is an ongoing concern. One in three Americans had health care records breached in 2015.²⁴² Recent hacks of U.S. hospital health care systems through the use of ransomware, viruses that hold systems hostage until victims pay for a key to regain access, further highlight the need for enhanced VA cybersecurity.²⁴³ VA's OIG has repeatedly identified the same weaknesses and deficiencies in VA's information security program in its annual FISMA audit reports.²⁴⁴ Although VA has recently made some progress in developing policies and procedures to address current security gaps, OIG's FY 2015 audit concluded that information security is still a *material weakness* for VA and that VA must take comprehensive measures to mitigate security vulnerabilities affecting VA's mission-critical systems.²⁴⁵ For sharing of veteran data to be secure, only the designated correct parties can have access to patients' data.²⁴⁶ Interoperability increases the risk to veterans' health records.²⁴⁷ Cybersecurity guidelines and best practices are being developed by HHS in response to the requirements in the recently enacted Cybersecurity Information Sharing Act;²⁴⁸ however, security protocols also cannot impede health information exchange with VA community providers and health systems. VA OIT needs to be involved in the health information exchange planning discussions, which

²³⁹ "Interoperability 2015: Current State and Next Steps", Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁰ "Analysis of Unique Patient Identifier Options," Solomon I. Appavu, The Department of Health and Human Services, accessed May 20, 2016, <http://www.ncvhs.hhs.gov/wp-content/uploads/2014/08/APPAVU-508.pdf>.

²⁴¹ "The Right Fit: How We Solve the Puzzle of Interoperability," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/telemedicine/the-right-fit-how-we-solve-the-puzzle-of-interoperability>.

²⁴² "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 25, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

²⁴³ "Virus Infects Medstar Health System's Computers, Forcing an Online Shutdown," John Woodrow Cox, Karen Turner and Matt Zapotosky, accessed March 28, 2016, https://www.washingtonpost.com/local/virus-infects-medstar-health-systems-computers-hospital-officials-say/2016/03/28/480f7d66-f515-11e5-a3ce-f06b5ba21f33_story.html?hpid=hp_local-news_medstar-health-virus-345pm_percent3Ahomepage_percent2Fstory.

²⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, A-24, accessed May 25, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁴⁵ Department of Veterans Affairs, Office of the Inspector General, *Federal Information Security Modernization Act Audit for Fiscal Year 2015*, accessed May 25, 2016, <http://www.va.gov/oig/pubs/VAOIG-15-01957-100.pdf>.

²⁴⁶ "Interoperability 2015: Current State and Next Steps; Market Immaturity Highlights Opportunity," Kent Gale, KLAS Research, accessed March 9, 2016, <http://www.klasresearch.com/docs/default-source/default-document-library/2pg-emr-interoperability-industry-specific.pdf?sfvrsn=0>.

²⁴⁷ Jon White, M.D., The Office of the National Coordinator for Health Information Technology, briefing to Commission on Care, December 15, 2015.

²⁴⁸ "Public Health Enemies: Protecting Your Medical Records," Russell Branzell, Media Planet: Future of Health Care, accessed May 17, 2016, <http://www.futureofhealthcarenews.com/digital-health/public-health-enemies-protecting-your-medical-records>.

COMMISSION ON CARE FINAL REPORT

are currently handled solely within VHA, so that VA OIT can assist in removing impediments to health information exchange.²⁴⁹

Veterans currently have to opt in (i.e., provide consent) to allow VA to share their health information with non-VHA/community care providers. Although the technology is in place for VA to exchange patient health information with more than 100 health information exchange partners, only a fraction of data can be exchanged in these networks because, due to lack of awareness, only 3 percent of veterans have opted in to allow VA to share their health information.²⁵⁰ The standard industry policy is to have patients opt out of having their health data shared with their other health care providers. VA is prohibited from taking this approach because statutory language in 38 U.S.C. § 7332 prohibits VA from disclosing information relating to drug abuse, alcoholism or alcohol abuse, infection with the human immunodeficiency virus, or sickle cell anemia, except when required in emergencies, without written authorized consent from the patient.²⁵¹

In response to this limitation, VA approved and submitted Legislative Proposal VHA-10 (10P-07), Authority for the Department of Veterans Affairs (VA) to Release Patient Information under 38 U.S.C. § 7332 to Health Care Providers for Treatment of Shared Patients in 2013. The proposal allows veterans to opt out of sharing their data with VA community providers instead of having to opt in. The proposal was approved by OMB and was included in the president's 2015 Budget. VHA provided a briefing to a Senate Veterans Affairs Committee staff in April 2015 on this legislative proposal. A House Bill was introduced, but it limited the opt-out option to the *Choice Program*. VA's Office of Congressional and Legislative Affairs responded back to Congress that the bill should be expanded to include all external purchased care options (i.e., community providers) thus directly supporting more veterans.²⁵²

Collaboration between VA OIT and VHA is paramount to transforming VHA's health IT infrastructure. Such collaboration would be most effectively achieved by establishing an IT leader for VHA who is focused on ensuring that the strategic and operational IT needs of VHA clinicians, staff, and veterans are met. Current OIT leadership is in the process of modernizing VA's IT management processes, to include putting in place IT account managers (ITAMs) for each of the agency's departments, including VHA.²⁵³ An account manager is neither senior enough, nor has the level of expertise and experience, to manage the complexity of the VHA IT system. VHA's extensive IT needs require a VHA CIO with authority over the health IT budget and the execution of the health IT strategy. VA needs a robust process for IT investment decisions, especially those relating to VHA's health strategy. The VHA CIO would work with the CVCS and the VA CIO to define the health IT strategy and key IT acquisitions/projects and ensure that health IT funding is aligned and committed to the execution of VHA's health IT

²⁴⁹ Jamie Bennett, VLER Health Program Manager, phone call with Commission on Care Staff, March 2, 2016.

²⁵⁰ Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015.

²⁵¹ 38 U.S.C. § 7332 Subchapter III - Protection of Patient Rights Sec. 7332 - Confidentiality of certain medical records.

²⁵² Elaine Hunolt, email on February 1, 2016 in response to follow-up questions from her briefing to the Commission on Care, December 15, 2015.

²⁵³ "OI&T Enterprise Strategy: Putting Veterans First," LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care, December 15, 2015.

strategy. Rolling out a new system takes multiple years, and VA must commit to funding system deployments to completion.

The modernization of VHA's IT infrastructure requires a substantial increase in and reallocation of VA's IT budget to implement it. The budget process for VA health care IT funding should be the same as the process for VHA medical care funding. That shift can be accomplished by establishing a separate line item for *health* IT within VA's IT appropriation, and providing for advanced appropriations for that account. In addition, there is also a potential supplementary role for government-wide IT legislation. For example, H.R. 4897, the Information Technology Modernization Act of April 2016, would create a \$3.1 billion revolving fund for upgrading outdated federal IT systems.²⁵⁴

The Commission strongly recommends that VA purchase a comprehensive COTS health IT platform, and implement all information systems with minimal customization. VHA leadership is in the process of assessing whether VistA is the best solution to support veterans' future health care needs or whether a new EHR, such as a COTS product or open-source EHR, should be used.²⁵⁵ The decision to choose a COTS product would be consistent the approach adopted by DoD and by other large health systems that have moved away from homegrown solutions to commercial and open-source products. It would allow VHA to focus energy on excellent patient care as a core competency and shift the IT development and maintenance risk of software products to external vendors with more expertise in this area.²⁵⁶ It is also likely to accelerate interoperability as vendors continue to offer IT solutions that meet meaningful use standards and the roadmap published by ONC.

A COTS product must be able to execute key functionalities required by VHA. These requirements include one standard version of an EHR across all VHA sites of care; interoperability within VA, such as with Veterans Benefit Administration (VBA), and between VHA and DoD, and community providers; robust security; and the ability to accommodate a national unique patient identifier. This system must also be a robust clinical management tool that supports VHA clinical workflow and has a customizable interface for clinical users, allows for evidence-based clinical order sets and patient safety features like automated medication reconciliation, has robust analytic capability for both clinical and administrative functions, and enables automated abstraction and reporting of performance measures.

The system must also seamlessly support administrative functions like scheduling, patient intake, eligibility determination, referrals, and patient out-of-pocket expense determination. The system must enable effective business operations in billing coding, automated claims processing, and all aspects of supply chain management. This COTS purchase should include a scheduling package. Improvements in scheduling should dramatically increase access and satisfaction, as well as data quality, productivity, and operational reporting capabilities.

²⁵⁴ "Two IT Modernization Bills Could See Movement in Congress," Aisha Chowdhry, accessed April 28, 2016, <https://washingtontechnology.com/articles/2016/04/22/it-bills-congress.aspx>.

⁷³ Sloan Gibson, Deputy Secretary of Veterans Affairs et al., briefing to Commission on Care, April 18, 2016.

²⁵⁶ "DoD awards Cerner, Leidos, Accenture EHR Contract," Tom Sullivan, accessed May 12, 2016, <http://www.healthcareitnews.com/news/dod-names-ehr-contract-winner>.

COMMISSION ON CARE FINAL REPORT

Broadening and improving scheduling capabilities will provide more opportunities for veterans to become active partners in their own care.²⁵⁷

For VHA to transition to a COTS product, the new VHA CIO must develop and implement a strategy that will allow the current nonstandard data to effectively roll into a new system, engage clinical-end users and internal experts in the procurement and transition process, ensure effective cybersecurity, and limit spending on the current systems to fund only critical changes required for continued operations. Finally, this plan should be coordinated with ONC and DoD.

Implementation

Legislative Changes

- Provide a specific appropriation to fully fund the complete development and deployment of the comprehensive COTS electronic health platform, recognizing this will require significant resources above the current annual appropriation and funding to support VHA's IT transformation; including funds that ensure appropriate training of all staff, recognize loss of staff productivity during implementation, and provide proper maintenance and upgrades of VA IT infrastructure in preparation for new and successor technologies.
- Establish within the Department's IT appropriation a line item for health IT, and provide for advanced appropriations for that account, consistent with the overall VHA IT strategy.
- Amend section 38 U.S.C. §7332, to authorize VA to share protected health information under the same rules as all other HIPAA protected information.

VA Administrative Changes

- Hire a CIO for the VHA IT transformation. The CIO should report to the CVCS, with secondary reporting responsibility to VA CIO.
- Establish a transformation strategy that addresses all of the following needs (as directed by the VHA CIO):
 - standardizes data elements in the current IT systems through the use of standard nomenclatures, terminologies and code sets in order to promote the transition to a COTS EHR and to support interoperability²⁵⁸
 - develops a robust cybersecurity plan for VHA IT infrastructure, in coordination with VA CIO and Chief Information Security Office, which addresses both current systems and defines
 - the requirements for new systems

²⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, 46, accessed May 3, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁵⁸ Ibid., 55.

- collaborates with the Office of the National Coordinator for Health IT on national interoperability standards and implementation
- limits any continued VistA development and associated spending to only those upgrades required to keep VistA functioning until a new system is in place
- Plan and implement procurement of a comprehensive COTS electronic health platform that executes all of the following requirements:
 - establishes one logical version of an electronic health record platform in VHA²⁵⁹
 - standardizes evidenced-based, best practice clinical order sets across VHA
 - incorporates effective analytic capabilities to drive health and business outcomes and offers the ability to interface with other tools for data management and presentation²⁶⁰
 - modernizes appointment scheduling so that it accurately measures wait times, is not susceptible to data manipulation, and is focused on the individual needs of the veterans²⁶¹
 - accomplishes a coordinated IT infrastructure for appointment scheduling, coding, billing, claims payment, third party collections, and other core VHA business processes, including the following specific capabilities: integration across patient intake, medical records, coding, and billing systems; single sign-on capability; automated first-party claims matching; real-time estimate of out-of-pocket patient expenses; and automation to support algorithmic edits and claims correction²⁶²
 - supports the business processes required to implement integrated community care networks, including eligibility determinations, referrals and authorizations, care coordination, network management, claims and customer service
 - promotes full interoperability with IT systems across VA (including VBA and National Cemetery Administration) and between VA and DoD
 - supports the development of full interoperability with integrated community care network facilities and providers

²⁵⁹ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

²⁶⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, viii, accessed March 31, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

²⁶¹ The Independent Budget, *The Independent Budget—Veterans Agenda for the 114th Congress: Policy Recommendations for Congress and the Administration*, accessed May 17, 2016, http://www.independentbudget.org/2016/IB_FY16.pdf.

²⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 49, accessed February 16, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

COMMISSION ON CARE FINAL REPORT

- enables automated abstraction and reporting of quality performance measures including process and outcome measures of clinical quality, access measures, and cost effectiveness that are the same as the private sector
- includes functionality to use a national unique patient identifier
- integrates supply chain and financial systems with the electronic health records to provide accurate operational data²⁶³
- Streamline its current IT procurement processes so that IT procurement is expeditious, including lengthier contract vehicles with more options, the use of indefinite delivery indefinite quantity vehicles, blanket purchase agreements, time and material contracts, and flexible contract structures to allow for the onboarding of emerging technologies in a competitive fashion.
- Increase health IT expertise within VHA.

Other Department and Agency Administrative Changes

- CMS and federal health care providers should collaborate to develop a national unique patient identifier standard. CMS should require health care providers to use these identifiers as a condition of participation in Medicare and HHS should require federally qualified health centers to use them as a condition of participation. The President should require all federal health care providers to adopt the standard.

²⁶³ LaVerne Council, Assistant Secretary for Information & Technology, Chief Information Officer, Department of Veterans Affairs, briefing to Commission on Care staff, April 27, 2016.

Supply Chain

Recommendation #8: Transform the management of the supply chain in VHA.

Problem

Effective management of all aspects of the supply chain has become a competitive differentiator for health care delivery systems. Modernization and automation of the supply chain in health care have the potential to save hundreds of millions of dollars, if done well. VHA cannot modernize its supply chain management and create cost efficiencies because it is encumbered with confusing organizational structures, no expert leadership, antiquated IT systems that inhibit automation, bureaucratic purchasing requirements and procedures, and an ineffective approach to talent management.

The problems are systemic. The organizational structure is chaotic, contracting operations are not aligned to business functions, and processes are poorly constructed, lacking standardization across the organization. Information technology infrastructure is inadequate, and it lacks appropriate interoperability among IT systems. VHA is unable to produce high-quality data on supply chain utilization and does not effectively manage the process using the insights such data could provide.²⁶⁴

Background

Health systems nationwide, under pressure from reforms driven by the Affordable Care Act, are looking at every aspect of their business to maximize cost savings, while maintaining quality services.²⁶⁵ This effort includes examining the supply chain for ways to save money.²⁶⁶

The Commission Recommends That . . .

- VHA establish an executive position for supply chain management, the VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- VA and VHA reorganize all procurement and logistics operations for VHA under the CSCO to achieve a vertically integrated business unit extending from the front line to central office. This business unit would be responsible for all functions in a fully integrated procure-to-pay cycle management that includes policy and procedures, contract development and solicitation, ordering, payment, logistics and inventory management, vendor relations and integration, data analytics and supply chain visibility, IT alignment, clinician engagement and value analysis, and talent management across all these supply chain functions.
- VA and VHA establish an integrated IT system to support business functions and supply chain management; appropriately train contracting and administrative staff in supply chain management; and update supply chain management policy and procedures to be consistent with best practice standards in health care.
- VHA support the Veterans Engineering Resource Center (VERC) Supply Chain Modernization Initiative including consistent support from leadership, continued funding and personnel, and the alignment of plans and funding within OIT to accomplish the modernization goals.

²⁶⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, vi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁶⁵ Bob Kehoe, "Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness," *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

²⁶⁶ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "5 Ways Supply Chain Can Reduce Rising Health Care Costs," Jasmine Pennie, accessed April 28, 2016, <http://hitconsultant.net/2013/05/13/5-ways-supply-chain-can-reduce-rising-health-care-costs/>.

COMMISSION ON CARE FINAL REPORT

Price competition achieved through technology and aggressive management of supply chain efficiencies by retailers such as Walmart and Amazon are held up as just the kind of disruption that health care requires.²⁶⁷ Health care organizations as diverse as Kaiser Permanente, Cleveland Clinic, Stanford Medicine, and Johns Hopkins Health System have taken on the challenge of transforming their supply chains, realizing savings of as much as hundreds of millions of dollars.²⁶⁸ VHA, which in FY 2014 spent approximately \$3.4 billion on clinical supplies, medical devices, and prosthetic appliances, has an opportunity to realize similar savings.²⁶⁹

Opportunities for efficiency in the supply chain include reducing pricing for purchases and lowering operating costs of procurement processes. To achieve price savings, organizations must have detailed information on what products they use, understand and reduce variability in the products purchased, and aggressively negotiate pricing, usually by consolidating purchases to a small number of preferred vendors who are willing to offer volume discounts and improve service delivery. On the operations side, cost savings are achieved by managing inventory lifecycle and restocking processes; order management; and the logistics of shipping, receiving, and transportation to drive down costs and lower waste and breakage. In health care, it also pays to ensure that clinical staff, both nurses and doctors, are treating patients rather than conducting inventory checks or ordering and collecting supplies.²⁷⁰ To be successful in managing the supply chain in health care, a partnership with clinical staff is key. Variability in device and supply purchases can be driven by clinician preferences and thus, to reduce variability, clinicians must be engaged in analyzing product options and examining data on product effectiveness to determine what products to use with patients.²⁷¹

VHA has a successful internal model of aggressive supply chain management that can serve as a model for improving the management of medical, surgical and other supplies: the VHA Pharmacy Benefits Management Service (PBM). PBM has taken a systems approach to

²⁶⁷ John Agwunobi and Paul London, "Removing Costs from the Health Care Supply Chain: Lessons from Mass Retail," *Health Affairs*, 28, no 5, (2009): 1336-1342, accessed April 26, 2016, <http://content.healthaffairs.org/content/28/5/1336>.

²⁶⁸ "In Age of Mergers, Hospitals Get Strategic with Medical Supply Purchasing," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/age-mergers-hospitals-get-strategic-medical-supply-purchasing>. "Supply Chain Management," Cleveland Clinic, accessed April 27, 2016, <http://my.clevelandclinic.org/services/supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

²⁶⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 47, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁰ "EY Provider Post: Choosing Your Innovation Pathway," EY, accessed April 26, 2016, <http://www.ey.com/US/en/Industries/United-States-sectors/Health-Care/Provider-Post--Choosing-your-innovation-pathway>.

²⁷¹ "Supply Chain Efficiency Trends," Rodney Moore, accessed April 28, 2016, <http://www.healthcarefinancenews.com/news/supply-chain-efficiency-trends>. "Strategic Supply Chain Management," Lee Ann Jarrow, accessed April 28, 2016, <http://www.hhnmag.com/articles/4522-strategic-supply-chain-management>. "Stanford Medicine Cuts Medical Supply Costs Through Value-Based Ordering," Jeff Lagasse, accessed April 27, 2016, <http://www.healthcarefinancenews.com/news/stanford-medicine-cuts-medical-supply-costs-through-value-based-ordering>.

managing pharmaceutical supplies, logistics, and prescribing.²⁷² PBM has largely solved the internal contracting deficiencies in VA by consolidating its activities under just two contracting organizations that oversee all national-level contracts for pharmaceuticals. PBM also applies effective mechanisms to drive standardization of supplies through a national formulary, clinical guidelines for prescribers and utilization review, and feedback to help clinicians identify outlier prescribing practices.²⁷³ Vital to the success of this program is the involvement of clinicians and pharmacists in a vertically integrated model of engagement and decision making through facility-level, Veterans Integrated Service Network (VISN)-level, and national-level PBM committees that contribute to formulary and clinical guideline decisions and manage utilization review with local clinicians.²⁷⁴ PBM also has a sophisticated web of communications, education, and engagement efforts to ensure clinical leaders across the system are helping drive PBM policy and practices.²⁷⁵ As a result, 90 percent of purchases are acquired through pharmaceutical prime vendor contracts.²⁷⁶

PBM, taking advantage of standardized industry nomenclature and bar codes for pharmaceuticals, has implemented automated dispensing, distribution, and ordering processes, including VA's Consolidated Mail Outpatient Pharmacy (CMOP).²⁷⁷ The use of CMOP, a system of seven highly automated pharmacies that process more than 460,000 prescriptions every work day, results in exceptional accuracy and lower processing costs than would result if filling prescriptions at each VAMC.²⁷⁸ Eighty percent of prescriptions in VHA are filled through CMOP,²⁷⁹ which has been recognized for the last 6 years as the best or one of the best mail order pharmacies in the country meeting or exceeding customer satisfaction scores of health care systems like Kaiser Permanente and on-line pharmacies like Express Scripts and Walgreens Online Pharmacy.²⁸⁰ Customer service, veteran satisfaction, and patient safety delivered through team-based care are a hallmark of the mission of PBM,²⁸¹ and are a useful reminder of the principles that must drive any successful transformation of supply chain management in VHA.

²⁷² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 19, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷³ *Ibid.*, 20.

²⁷⁴ VHA Formulary Management Process, VHA Handbook 1108.08 (2009).

²⁷⁵ Clinical Pharmacy Services, VHA Handbook 1108.11, 28-30 (2015). The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 32-34, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁷⁷ *Ibid.*

²⁷⁸ "VA Mail Order Pharmacy," U.S. Department of Veterans Affairs, accessed April 29, 2016, http://www.pbm.va.gov/PBM/CMOP/VA_Mail_Order_Pharmacy.asp.

²⁷⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 13, accessed January 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸⁰ "U.S. Pharmacy Study – Mail Order (2015)," J.D. Power, accessed April 29, 2016, <http://www.jdpower.com/ratings/study/U.S.-Pharmacy-Study-Mail-Order/631ENG>.

²⁸¹ "Pharmacy Benefits Management Services," U.S. Department of Veterans Affairs, accessed April 29, 2016, <http://www.pbm.va.gov/PBM/index.asp>.

COMMISSION ON CARE FINAL REPORT

Analysis

VHA's supply chain for clinical supplies, medical devices, and related services is inadequate compared to the agency's pharmacy organization or to best practices in leading hospital systems.

*Its contracting processes are bureaucratic and slow, which can delay veterans access to care. Purchasing processes are cumbersome which has driven VHA staff to work arounds and exacerbates the variation in prices VA pays for products. Utilization is difficult to measure or manage given a lack of data which likely leads to significant avoidable expense for VA.*²⁸²

Leadership and Organizational Structure and Function

Best-in-class supply chain organizations typically have a single group responsible for the strategy, sourcing, procurement, and logistics of clinical supplies and medical devices. The organization is typically led by an executive-level leader, such as a chief supply chain officer (CSCO), and personnel are aligned along product categories to develop and use deep expertise in the products and suppliers they manage.²⁸³ In contrast, the organizational structure for contracting, logistics, and supply management in VA and VHA is complex and duplicative.²⁸⁴ Four contracting entities are located within VA central office but report to two different management offices within VA's office of acquisition, logistics, and construction (OALC).²⁸⁵ Procurement personnel within VHA's regional contracting and VISN offices report to VHA's national office of procurement. In contrast, facility-based and VISN logistics personnel report to their local VAMC or VISN director and not to the national VHA logistics office.²⁸⁶ To further complicate the management picture, clinical supplies are managed by the logistics organization, yet medical devices are managed by the Prosthetics and Sensory Aid Service (PSAS)²⁸⁷ (see Figure 5). In most health care organizations, the supply chain chief operating officer and their integrated supply chain group manages the procurement and distribution of all clinical supplies and medical devices.²⁸⁸ This is not the case in VA. Senior leaders in VA's and VHA's supply chain organizations and field-based supply chain personnel indicate current organizational structure is too complex and should be simplified.

*National supply chain leaders expressed lack of clarity regarding the scope of responsibilities of the entities for which they are responsible, which has led to some tension and what one leader described as a 'turf war.' Others described a vacuum of ownership and accountability, and lack of clarity on roles and responsibilities.*²⁸⁹

²⁸² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, v, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁸³ Ibid., 57-58.

²⁸⁴ Ibid., ix.

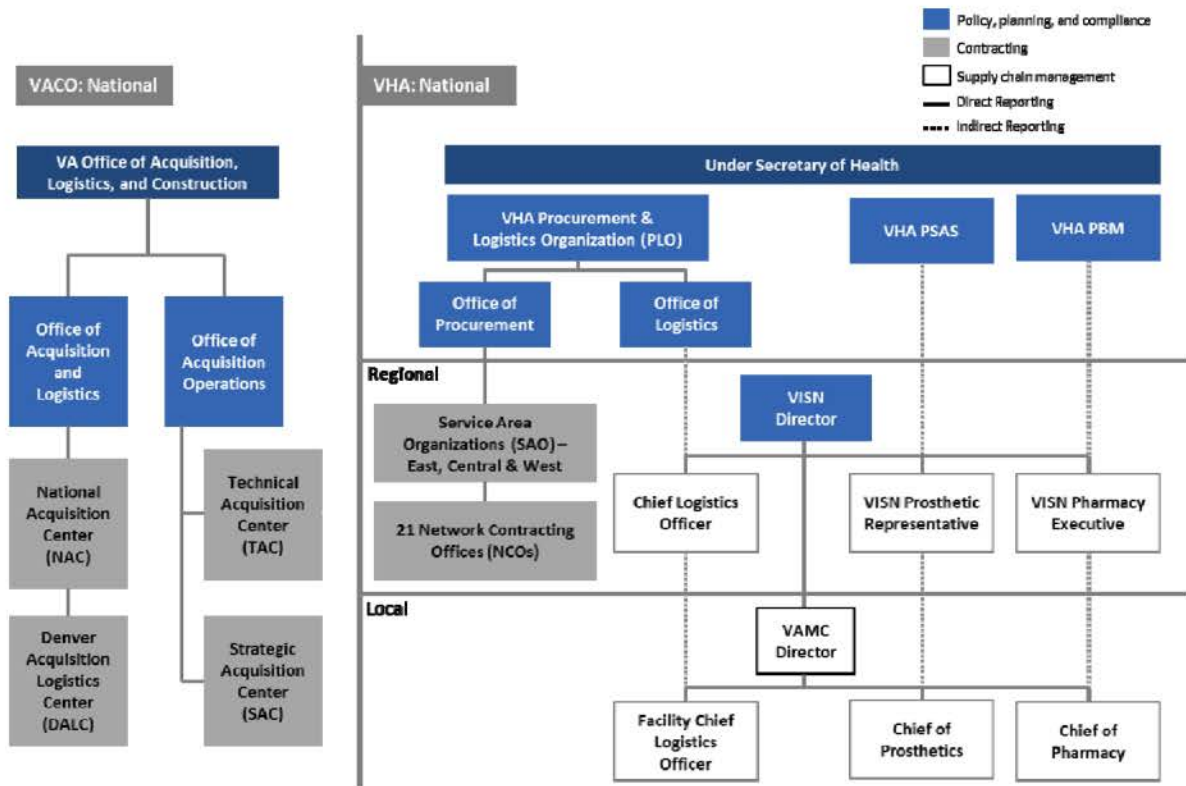
²⁸⁵ Ibid., 96-97.

²⁸⁶ Ibid., 47-50.

²⁸⁷ Ibid., 58.

²⁸⁸ Ibid.

²⁸⁹ Ibid., 55.

Figure 5. Organizations Comprising VA's Supply Chain²⁹⁰

Note: Some VISNs may have different reporting relationships with facility prosthetics staff.

The separation of clinical supplies and prosthetics/medical devices causes issues in coordinating products needed for procedures. Frontline staff members indicate the time it takes to procure simple items through contracting (1 to 3 months) is problematic. For example, heart valve surgery may be delayed because some heart valves cost more than the micro-purchase threshold (\$3,000), thus the purchase must be made through the contracting process.²⁹¹ Medical center staff consistently expressed concern that VHA procurement offices are not responsive to the needs of a health care organization and do not communicate effectively with them,²⁹² findings borne out by low customer satisfaction scores given to these organizations.²⁹³

There is great overlap and redundancy in procurement and logistics functions in VA and VHA and the reporting structures are not aligned to ensure that the needs of veteran patients and their clinical providers are met. In an environment with limited sharing of best practices and a lack of transparent, open communications, the current complicated reporting structures impede customer-service quality and effectiveness. The original intent behind the current structure was to consolidate and strengthen purchasing power through the establishment of national contracts; however implementation of the vision has been poor and the result has been a

²⁹⁰ Ibid., 49.

²⁹¹ Ibid., 67.

²⁹² Ibid., 68.

²⁹³ Ibid., 69.

COMMISSION ON CARE FINAL REPORT

complicated, bureaucratic system filled with redundancies.²⁹⁴ These broken processes serve as a precursor for catastrophic systems failures.²⁹⁵

There is an immediate need to consolidate and streamline procurement and logistics for medical and surgical supplies under one leader in VHA, the VHA chief supply chain officer (CSCO), who would be accountable for transforming VHA supply chain management. As identified under MyVA, medical and surgical supply chain management is the first priority but the rest of the supply chain needs to be addressed by the CSCO in a staged approach. The VERC or other experts in business process engineering must be engaged to create a vertically aligned organizational structure with clear delegated responsibilities at each level of the organization to create an efficient and responsive procurements and logistics process which the VHA CSCO would lead.

Clinical Engagement and Value Analysis

In contrast to pharmaceuticals, usage of clinical supplies and medical devices is not strictly monitored or managed in VA. In general, physicians and nurses can choose whichever products they believe are best for patients and the supply chain organization's role is to make those items available.²⁹⁶

VHA does not have a means to determine what supplies should be standardized or a feedback loop administrators and staff use to assess whether standards were being used when they did exist.²⁹⁷ As a result, limited product standardization has been achieved across VHA, despite VHA establishment of national standardization user groups in 2001 responsible for identifying items for standardization based on national procurement data.²⁹⁸ To date, national product standardization has been achieved in only a limited number of categories.²⁹⁹ Since 2011,

VHA required that medical centers establish Clinical Product Review Committees (CPRCs) to: (i) review and approve the use of new clinical items and reusable medical equipment (RME) at each medical center; (ii) maintain a list of approved expendable clinical supplies and RME by establishing and maintaining a Medical/Surgical Supply Formulary; and (iii) ensure compliance with nationally standardized contracts and blanket purchase agreements. In all sites visited, CPRCs exist and meet regularly but reviews were generally formalities.³⁰⁰

²⁹⁴ Ibid., 47-50.

²⁹⁵ Heather Woodward-Hagg, PhD, Acting Director, VERC, briefing to Commission on Care, February 8, 2016.

²⁹⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 54, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

²⁹⁷ Ibid., xii.

²⁹⁸ VHA Handbook 1761.1, Standardization of Supplies and Equipment Procedures, July 2003.

²⁹⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 81, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁰ Ibid., 82.

Under this 2011 policy, the establishment of VISN oversight committees was also required to provide accountability and feedback to the local committees, but these committees were apparently never established.³⁰¹

VHA, with the engagement of the Veterans Engineering Resource Center (VERC), is making progress on clinician alignment to accomplish value-based purchasing decisions for medical and surgical supplies. VERC has recently rolled out a national clinical product review committee (CPRC-E) e-portal to better organize this function. This portal provides a central system and standard processes for all new product requests and approvals to inform the procurement processes.³⁰²

In the area of medical and surgical supplies, clinician preference can drive variability in procurement and utilization. As has been done in VHA for pharmaceutical prescribing, a similar system to engage and align clinicians must be undertaken for medical devices and surgical supplies. VERC has started this process, but requires further funding and leadership support to fully implement a clinician-driven sourcing process. Current and future leaders of VA and VHA must ensure that VERC continues to receive the funding support and leadership engagement it needs to fully accomplish this transformation with support and direction from a VHA CSCO.

Information Technology, Data Standards, and Analytics

Information technology systems, data systems, and analytical capability for finance, inventory management, and purchasing impede VHA's ability to effectively manage its supply chain.³⁰³ VHA needs greater "end-to-end visibility into the operational and financial performance of their supply chain" and more effective means to accomplish supply chain budgeting, forecasting, inventory management and automation of at least some key supply chain functions.³⁰⁴

*VA lacks visibility into supplies and devices spending at the level of granularity usually seen in the private sector. For example, in the private sector, it is typically possible to measure clinical supply spend and utilization at the service, patient, or physician level. However, this is not possible in VHA because it does not capture such data. Therefore, supplies spend per case can only be calculated in aggregate, which is relatively meaningless and does not allow for fair comparison across hospitals, services, or physicians. This inhibits VA's ability to manage utilization and to understand fully the impact of product standardization efforts.*³⁰⁵

VERC is working to reduce the more than 130 versions of VistA in place across the country so that the same data sets can be tracked and reported.³⁰⁶ Funding was approved by OIT for the Future Transformation Tool (FTT) graphical user interface that will standardize product names

³⁰¹ Ibid., 54.

³⁰² Heather Woodward-Hagg, PhD, email to Commission on Care, March 17, 2016.

³⁰³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁴ Ibid.

³⁰⁵ Ibid., 60.

³⁰⁶ Ibid.

COMMISSION ON CARE FINAL REPORT

and provide data integration across all of VHA. Point of Use Solution, a commercial off the shelf supply management software product, has been purchased to achieve better inventory and demand management control and has been deployed to 32 percent of facilities, as of April 2016.³⁰⁷

True sustainment of a clinician driven process cannot be achieved with fragmented information systems that do not communicate. Leaders at all levels of the organization are not able to effectively identify and manage procurement requirements or provide effective feedback to clinicians on utilization. Similarly, automated inventory control, ordering, billing, and payment cannot occur without a seamless information technology infrastructure. With a current IT system in which fiscal, supply chain, and clinical informatics systems do not interface, the hopes of moving to automated processes for supply ordering, equipment life cycle management, and vendor communications cannot be realized. A plan for the transformation of supply chain management, developed by a VHA CSCO with support from VERC, must be fully integrated with planning and procurement within OI&T and fully financed to accomplish these important goals.

Policy and Procedures

Ninety-eight percent of all clinical supplies are acquired using purchase cards³⁰⁸ and 75 percent of what VHA spends on clinical supplies is made through this purchase mechanism.³⁰⁹ This is not a surprise given that the standard contracting process can take anywhere from 150 to 180 days to complete,³¹⁰ yet use of purchase cards is inefficient as this mechanism does not take advantage of economies of scale and potential cost savings an organization the size of VHA can achieve through price negotiations and strategic sourcing.³¹¹ It can also be contrary to law, as use of purchase cards often necessitates orders be split to remain under the \$3,000 purchase card limit.³¹² An analysis of purchase records showed that 38 percent of supply orders were made through standing vendor contracts which is in stark contrast to the private sector benchmark of aiming to complete 80-90 percent of supply purchases from master contracts with negotiated price discounts.³¹³ Indeed, the private sector trend in health care has been for hospitals and health care systems to form alliances in “group purchasing organizations” to achieve the scale that VHA naturally enjoys.³¹⁴ Weaknesses in logistic management have been recognized in VHA for some time and still remain.³¹⁵ For instance, a review of logistics business

³⁰⁷ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³⁰⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xi, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³⁰⁹ Ibid., xii.

³¹⁰ Ibid., x.

³¹¹ U.S. Government Accountability Office, *Strategic Sourcing: Improved and Expanded Use Could Save Billions in Annual Procurement Costs*, accessed April 28, 2016, <http://www.gao.gov/assets/650/648644.pdf>.

³¹² U.S. Department of Veterans Affairs, Office of Inspector General, *Review of Potential Inappropriate Split Purchasing at VA New Jersey Health Care System*, accessed April 28, 2016, <http://www.va.gov/oig/pubs/VAOIG-11-00826-261.pdf>.

³¹³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xii, accessed April 29, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³¹⁴ Bob Kehoe, “Transforming Purchasing: Expect Sharp Focus on Comparative Effectiveness,” *Health Facility Management Magazine*, 12, (2010): 34-37, accessed April 28, 2016, http://www.hfmmagazine.com/inc-hfm/pdfs/2010/10HFM12_Trends5.pdf.

³¹⁵ U.S. Government Accountability Office, *Veteran’s Health Care: VHA Has Taken Steps to Address Deficiencies in Its Logistics Program, but Significant Concerns Remain*, accessed April 28, 2016, <http://www.gao.gov/assets/660/653886.pdf>.

practices at 17 VHA medical facilities in 2014 showed that none of the facilities achieved 100 percent compliance on the factors assessed, and the rate of noncompliance ranged from 53 to 88 percent, depending on the business metrics examined.³¹⁶

VA is inhibited by a failure to update its acquisition regulations to take advantage of modernization made in 2014 to the governmentwide regulations to promote simplified purchasing procedures.³¹⁷

VERC initiatives to improve VHA supply chain are intended to standardize business processes and address the great price variations for the purchasing of medical and surgical supplies. A national medical surgical prime vendor (MSPV) contract has been established. This development has several advantages to include (a) increased ability to leverage pricing negotiations; (b) standardized pricing; (c) elimination of redundant contract development, bidding, and selection; and (d) future ability to integrate with CPRC E-Portal.³¹⁸ VA has established a goal for 85 percent of all orders in FY 2016 be made under the prime vendor contract and has made 1,100 contracting officers available to meet demand against the contract.³¹⁹ As of April 2016, an estimated \$24.4 million in supply chain costs had already been avoided since January.³²⁰

The establishment of a new MSVP contract in April 2016, the assignment of 1,100 staff to support its use, and the expectation communicated to the field that 85 percent of all purchases be made from the contract are important steps in the right direction. For efficient ordering processes to take hold and be sustained across VHA, all of the policies and procedures from the bedside (or surgical suite) to the head contracting office must be reworked to align with the desired business outcomes. Reworking policies and procedures must occur together with appropriate training and communication at all levels of the organization. Each staff member involved in the procurement process must be held accountable for meeting the new requirements and expectations assigned to them. Updating the VA Acquisition Regulation (VAAR) is just one small piece of such a transformational change. The VERC or others with appropriate experience in aligning business processes within government should be assigned responsibility to finish developing and implementing plans for such a transformation under the direction of a VHA CSCO.

Contracting

Analysis of the *Independent Assessment Report* confirmed issues with the responsiveness of contracting. For example, at one facility, if a request was submitted to contracting that was incomplete or inaccurate, it took on average 21 to 39 days from the date of initial submission to

³¹⁶ U.S. Department of Veterans Affairs, *VA Supply Chain News*, Issue 13, Jan/Feb 2015.

³¹⁷ Jonathan Miller, Director of Logistics Operations, VHA Procurement & Logistics Office, phone call with Commission on Care, December 9, 2015.

³¹⁸ Heather Woodward-Hagg, PhD, Acting Director, Veterans Engineering Resource Center, phone call with Commission on Care, March 18, 2016.

³¹⁹ Sloan D. Gibson, Deputy Secretary of Veterans Affairs, briefing to Commission on Care, April 28, 2016.

³²⁰ Ibid.

COMMISSION ON CARE FINAL REPORT

receive the first response from contracting requesting, for example, additional information or paperwork.³²¹ This problem appears to be a widespread.

In another instance, interviews conducted as part of the independent assessment showed that VA vendor contracting processes to order equipment valued at less than \$3,000, for example, scalars for dentistry, can be confusing and lengthy, leading to shortages in equipment and delays in clinic as equipment is located. Delays in sterile processing were also indicated by providers as an issue pertaining to equipment availability.³²²

Communication with contracting is another substantial challenge within VHA. In surveys that assessed the effectiveness of VA's contracting organization, VHA employees' customers rated the communications received from contracting officials the lowest of all contracting dimensions that were evaluated.³²³ Several interviewees recommended that VA provide more clarity on the status of contracting requests to help them plan and schedule care.³²⁴

Individuals in contracting believed that VAMC staff members were responsible for some of the delays in the contracting process. They reported that requests submitted to them from VAMCs were often incomplete or unclear and that facilities were poor at forecasting demand for items, leading to unpredictable peaks in demand for contracting services that exceeded their capacity. The VHA Procurement and Logistics Organization (PLO) and facilities are seeking to address these challenges by placing contract liaisons in facilities to better support contracting officer representatives throughout the process.³²⁵

Contracting compliance analysis showed substantial opportunity for improvement. Analysis of purchase order data showed that 38 percent of purchases were made on a government contract, 27 percent were made at open-market prices, and 34 percent did not have a source type specified.³²⁶ Private-sector organizations typically aim to buy 80 to 90 percent of their clinical supplies and medical devices on some type of negotiated contract.³²⁷

Interviews and observations undertaken as part of the independent assessment revealed that there are two primary reasons for VHA's relatively high share of open-market purchasing. First, in contrast to pharmaceutical purchasing, VHA's supply purchasing systems are not integrated

³²¹ The consulting team based this on an IFCAP/eCMS transmission log received during a VAMC site visit (2015). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²² Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 91, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

³²³ The consulting team derived this from a VHA procurement metrics book. McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, 69, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, x, accessed June 1, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

³²⁵ Ibid.

³²⁶ Ibid., xii.

³²⁷ Ibid.

with contract or pricing catalogs. Therefore, the purchasing process relies on buyers (often clinical staff) to research whether an item is on contract and through which contract a purchase should be made. Because of that complexity, several buyers reported that they bypass this step and buy products through the channel that is most familiar and convenient, for example, by replicating previous orders to their usual supplier, despite changes that may have occurred (new contracts and pricing arrangements, for example). Second, VHA has limited ability to monitor and drive compliance with the contract hierarchy because the required data are not captured electronically. In fact, more than 60 percent of all clinical supply items do not have a contract number listed.³²⁸

VHA's fragmented inventory management systems and processes also create challenges. VHA's current inventory management does not have a feedback loop to link inventory to product use, contracting, ordering, and vice versa. This lacking information prevents optimal use of the MSPV contract program and creates missed opportunities to establish more effective volume-based national or regional contracts. It also leads to peaks and troughs in demand for contracting services, which can overwhelm contracting's capacity.³²⁹

There are pockets of good performance and innovation in VHA that could be replicated across its supply chain. The *Independent Assessment Report* notes that the Denver Acquisition and Logistics Center (DALC) is a bright spot within VHA's supply chain organization in its acquisition and distribution of select devices such as hearing aids to veterans. It has developed an integrated operating model that brings together clinicians, contracting, finance, logistics, and program management. That integrated team makes decisions around product and supplier selection based on a holistic view of what is best for veterans and for VHA.³³⁰

Talent Management

VHA is unable to hire good talent to manage its supply chain. In 2014, 20 to 30 percent of logistics positions were unfilled, and 20 percent of medical supply aide jobs were vacant.³³¹ The causes were identified as lengthy time-to-hire, nonexistent internal career progression ladders for these individuals, and inability to provide competitive pay due to position downgrades made by OPM under Title 5.³³² Examples of recent downgrades include supply technician, mail manager, administrative officer, and materials handler.³³³

*It is well known in the health care industry that there is a shortage of supply chain talent currently. The private sector organizations interviewed during this assessment stated that they are recruiting more highly trained individuals than they did in the past and, because of competition for talent, are paying them more than they used to. This may be contributing to VHA's recruitment and retention challenges.*³³⁴

In Recommendation #15, the application of the more than 60-year old standards and processes used in the Title 5 personnel system does not serve the needs of a modern health care delivery

³²⁸ Ibid.

³²⁹ Ibid.

³³⁰ Ibid., xiii.

³³¹ Ibid.

³³² Ibid.

³³³ Ibid., 87.

³³⁴ Ibid., 88.

COMMISSION ON CARE FINAL REPORT

organization. Health care supply chain management is a recognized field of study and a valued component of leadership teams at the highest performing health care organizations. For VHA to compete for top leadership talent in this field and frontline staff, logistics and procurement personnel must be included in a new excepted personnel system for VHA under Title 38 (see Recommendation #15).

To address talent management issues, VERC has established a new VA Acquisition Academy (VAAA) Supply Chain Management School.

*The mission of the Supply Chain Management School is to provide best-in-class education, training, professional development, and certification of the VA supply chain workforce. VAAA's competency-based curriculum addresses general and technical skills, VA-specific functional areas, and core activities for VA logistics professionals. Emphasis is on translating theory, fundamentals, and concepts to practical application with realistic VA-based scenarios utilizing hands-on application of problem-solving skills.*³³⁵

The supply chain management school is organized under VAAA which has been recognized by external organizations to offer high quality training.³³⁶

Implementation

Legislative Changes

- Establish a new excepted personnel system under Title 38 to permit VHA to compete effectively with the private sector for personnel required to run a complex health care system, including staff to manage and operate a modern supply chain system.

VA Administrative Changes

- Establish an executive position for supply chain management, a VHA chief supply chain officer (CSCO), to drive supply chain transformation in VHA. This individual should be compensated relative to market factors.
- Transform policy and procedures for supply chain management in parallel with identification and procurement of new management software: new software should support the new processes and not the existing, poorly organized business processes and requirements.
- Establish a staged process for the transformation of all supply chain operations in VHA under the direction of a VHA CSCO, with support from VERC.
- Reconcile the VAAR with the Federal Acquisition Regulation (FAR) to ensure the VAAR aligns with recent updates to the FAR to permit streamlined acquisition processes.
- Provide consistent and standardized training to ensure those developing and administering contracts have updated information regarding FAR and VAAR

³³⁵ "Message from the Vice Chancellor," Veterans Affairs Acquisition Academy, accessed April 28, 2016, <http://www.acquisitionacademy.va.gov/schools/scm/message.asp>.

³³⁶ "VA Acquisition Academy Recognized as a 2016 Learning Elite Organization," U.S. Department of Veterans Affairs, accessed May 13, 2016, <http://www.acquisitionacademy.va.gov/rss/index.xml#20160413b>.

COMMISSION RECOMMENDATIONS

regulations as well as a thorough understanding of their responsibilities under the new approach to supply chain management and how to carry out these duties.

Other Department and Agency Administrative Changes

- None required.

Governance, Leadership, and Workforce

Board of Directors

Recommendation #9: Establish a board of directors to provide overall VHA Care System governance, set long-term strategy, and direct and oversee the transformation process.

Problem

The existence—and concealment—of unacceptably long delays in care at the Phoenix VA Medical Center (VAMC), and similar problems at multiple other VAMCs, had both direct and indirect causes. Weak governance was found to be among those indirect causes.³³⁷ As the authors of a root-cause analysis of the Phoenix scandal highlighted, “a governance gap in leadership continuity and strategic oversight from one executive leadership team to another” contributed to the wait-time problems.³³⁸ The report authors observed, “Unlike other health care systems, VHA does not have a governance mechanism to fill the role of a board of directors.”³³⁹ The governance limitations made evident in the Phoenix

scandal have profound implications for the long term. As discussed in this report, the Commission believes VHA must institute a far-reaching transformation of both its care delivery system and the management processes supporting it. Changes of the magnitude facing VHA would be difficult for any health care system to achieve. A transformation will take years to accomplish and must be sustained over time. Yet the short tenure of senior political appointees, each administration’s expectations for short-term results,³⁴⁰ and VHA’s operating in a “dynamic environment [in which it is] answering to a large number of stakeholders, sometimes with

The Commission Recommends That . . .

- Congress provide for the establishment of an 11-member board of directors accountable to the President, responsible for overall VHA Care System governance, and with decision-making authority to direct the transformation process and set long-term strategy. The Commission also recommends the governing board not be subject to the Federal Advisory Committee Act and be structured based on the key elements included in Table 5.
- The Board recommend a chief of VHA Care System (CVCS) to be approved by the President for an initial 5-year appointment. Additionally, the Commission recommends the governing board be empowered to reappoint this individual for a second 5-year term to allow for continuity and to protect the CVCS from political transition. If necessary, the CVCS can be removed by mutual agreement of the President and the governing board.

³³⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xvi, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³³⁸ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 3.

³³⁹ Ibid.

³⁴⁰ Ibid.

competing demands”³⁴¹ offer little reason for optimism that real transformation could take hold without fundamental changes in governance.

Background

VHA, as an agency within a cabinet department, is accountable to the secretary of Veterans Affairs (SECVA) and to the President. This framework, when it works well, can provide VHA access to, and support from, the President and White House staff. Like other executive branch agencies, VA and VHA undergo Office of Management and Budget (OMB) oversight; must win OMB approval of proposed rulemaking, budgets, IT development, and performance plans; and are also subject to governmentwide regulation of such areas as procurement, personnel, and property management. VHA health care and operations are subject to close congressional scrutiny.³⁴² VHA undergoes oversight from several independent bodies, including the internal Office of the Inspector General audits and external Government Accountability Office audits.

Within VA, VHA participates in the VA Executive Board (VAEB) and Senior Review Group, which are designated as the principal governance bodies of the department.³⁴³ VAEB serves as the department’s risk-governance board and determines VA’s strategic direction. VAEB oversees the department’s planning, programming, budgeting, and execution. Notwithstanding certain strengths inherent in this framework, VHA governance can be paralyzed by bureaucratic decision-making processes and competing stakeholder concerns.³⁴⁴

Among its principal recommendations, the *Independent Assessment Report* calls for “establishing a governance board to develop fundamental policy, define the strategic direction, insulate VHA leadership from direct political intervention, and ensure accountability for the achievement of established performance measures.”³⁴⁵

Analysis

In recent years, VHA leadership priorities and strategic direction have been unclear. Leaders have been consumed by crisis and by responding to congressional demands, creating a reactive, rather than proactive environment.³⁴⁶ Additionally, the leadership vision has lacked continuity.³⁴⁷ The SECVA and deputy secretary of Veterans Affairs may exercise oversight of

³⁴¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, xiv, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴² “Legislation,” U.S. House of Representatives, House Committee on Veterans’ Affairs, accessed June 15, 2016, http://veterans.house.gov/legislation?type=hearing&tid=All&tid_1=All&page=3. Over the course of calendar year 2015, the House Veterans Affairs Committee and its subcommittees alone held 18 oversight hearings relating to the Veterans Health Administration, with VHA and/or VA officials testifying as often as three times in a month.

³⁴³ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014).

³⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 26, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

³⁴⁵ *Ibid.*, 23.

³⁴⁶ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 52-54.

³⁴⁷ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, vi-viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Linda Belton, former VHA VISN Director and Director of National Center for Organizational Development, written submission to the Commission on Care Staff, January 19, 2016.

COMMISSION ON CARE FINAL REPORT

VHA and try to impose accountability, but incumbents do not necessarily have experience in federal health care administration or delivery.³⁴⁸ The SECVA has often lacked independent information and metrics on VHA performance, and the oversight, risk management, and compliance functions of VHA report to the undersecretary for health (USH) or to lower officials in VHA.³⁴⁹

Previous studies, dating back 20 years,³⁵⁰ have proposed fundamental change in VHA's governance and government structure, to include a proposal that it be restructured as a government corporation.³⁵¹ The earliest rationale for making VHA a government corporation was based on the view that the system needed a new service-delivery strategy,³⁵² and envisioned specific legislation to permit the corporation to operate more expansively under a wide range of reforms.³⁵³ Although the authors of the 1996 report presented a VHA government

³⁴⁸ Department of Veterans Affairs Governance Structure, VA Directive 0214 (2014). McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, viii, accessed June 15, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf. Under Secretary of Health, 38 U.S.C. § 305. While statute requires the USH of VHA to be appointed "solely on the basis of demonstrated ability in the medical profession, in health-care administration and policy formulation, or in health-care fiscal management; and on the basis of substantial experience in connection with the programs of the Veterans Health Administration or programs of similar content and scope" there is no such selection criteria for the VA Secretary or VA Deputy Secretary. Of the eight men to hold the position of Secretary of Veterans Affairs, only one, James Peake would qualify to be USH ("United States Secretary of Veterans Affairs," Wikipedia, accessed June 15, 2016, https://en.wikipedia.org/wiki/United_States_Secretary_of_Veterans_Affairs#List_of_Secretaries_of_Veterans_Affairs) and of the six men to hold the position of DEPSECVA, none would qualify to be USH.

³⁴⁹ Department of Veterans Affairs, *2014 Functional Organizational Manual v2.0: Description of Organization Structure, Missions, Functions, Tasks, and Authorities*, 57-58, accessed June 15, 2016, http://www.va.gov/ofcadmin/docs/va_functional_organization_manual_version_2.0a.pdf.

³⁵⁰ Veterans Benefits Improvement Act of 1994, Pub. L. No. 103-446, 108 Stat. 4645 (1994). In 1994, Congress in sec. 1104 of Public Law 103-446 called for an independent examination of the justifiability of establishing an alternative government structure to provide health care services for veterans, culminating in the 1996 report.

³⁵¹ Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. A government corporation has been described as "a government agency that is established by Congress to provide a market-oriented public service and to produce revenues that meet or approximate its expenditures." Kevin R. Kosar, Congressional Research Service, *Federal Government Corporations: An Overview*, 2, accessed June 15, 2016, <https://fas.org/sgp/crs/misc/RL30365.pdf>. Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report* September 22, 2015. Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed June 15, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>. Commission on the Future for America's Veterans, *Preparing for the Next Generation*, 3, accessed June 15, 2016, http://s3.amazonaws.com/siteninja/site-ninja1-com/1438121489/original/2014-05_Commission-Report-on-America-Veterans.pdf. That task force study, for example, called for an independent governance model and stated that "the operational structure of VHA does not lend itself to progress. Due to its size, governmental structure and geographic extension it does not readily foster innovation and faces challenges in addressing the politics of changing demographics and ancient facilities." The study report states, "VHA provides excellence in care in spite of its operations/governance structure, not because of it."

³⁵² Klemm Analysis Group, Lewin Group, Arthur Anderson LLP, *Feasibility Study: Transforming the Veterans Health Administration into a Government Corporation* (Washington, DC: Department of Veterans Affairs, 1996), 23. The strategy was premised in part on the view that VHA would be operating in a resource-constrained environment and lacked the resources it would need to invest in making significant changes.

³⁵³ Ibid. The 1996 report proposed such measures as providing VHA authority to seek additional revenue streams, to include billing and keeping funds from Medicare, Medicaid, and other government sources; authorizing it to invest nonappropriated funds; developing a trust fund for deposit of Medicare taxes by active-duty personnel; incorporating VHA as a Federal Employee Health Benefits Plan selection; allowing it to become part of health maintenance organization (HMO) networks and open HMO enrollment to veterans; changing appropriation law to create

corporation as a means of achieving specific objectives, those objectives were largely met (though ultimately not fully sustained) by reforms within existing government structures and processes set in place by former USH Kenneth W. Kizer.³⁵⁴

Nearly 20 years later, the report analyzing the root causes of delayed care at the Phoenix and other VA centers proposed creation of “governance mechanisms to bridge ‘Secretary suite’ leadership transitions and provide more stable strategy, oversight, and stewardship.”³⁵⁵ Explaining that “the study team feels that the complexity of this organization requires a more stable and professionalized governance model that more closely resembles the governance of large health care systems in the private sector,”³⁵⁶ the study authors proposed the creation of a board-of-directors-type oversight board to set the strategy for the organization, define priorities, provide operational oversight, and review budget requests. “The board would . . . create a body that would be the steward of the organizational vision, providing institutional memory and continuity as senior political appointees transition.”³⁵⁷

Frequent turnover of the USH is a critical problem. Recently, each USH has served for only a relatively short period, leaving office with a change in administration or sooner. This pattern has deprived VHA of vitally needed sustained leadership and has likely contributed to short-term decision making. VHA history shows a connection between longer tenure and transformative accomplishment.³⁵⁸ As testimony to the Commission from three former USHs would indicate, brevity of tenure tends to limit leaders’ strategic horizon and create a pattern of leadership discontinuity. Because transformative change can only be realized through many years of focused leadership, VHA and those who depend on it cannot afford the senior leadership turnover routinely associated with a change in administration.

The complex, sustainable transformation VHA needs will take years to implement. To succeed, VHA needs strong, consistent leadership and a governance framework that can assure effective development and execution of transformation plans over time. The current governance structure emphasizes operational, rather than strategic priorities; experience has shown it to be incapable of sustaining transformational change. Establishing a well-designed, overarching-governance model would provide an opportunity to achieve objectives shared by both the executive and legislative branches.

To be effective, a VHA Care System governance model should be empowered with a governing board that exercises fiduciary-like responsibilities (not subject to the Federal Advisory Committee Act) to carry out the following key functions:

multiyear/no-year appropriations; reforming human resources management practices for increased flexibility in hiring and firing, compensation, leave, and other functions; and reforming; and reforming procurement and contracting.

³⁵⁴ Ibid., 46, 48. The Klemm report saw a VHA corporation as having greater capacity to focus on strategic as well as short term goals; greater results orientation; greater flexibility; greater capacity to replicate and develop best practices; upgraded staff competence and expertise at senior levels; and greater political independence.

³⁵⁵ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 59.

³⁵⁶ Ibid.

³⁵⁷ Ibid.

³⁵⁸ See Dr. William S. Middleton, Chief Medical Director (1955-1963) and Dr. Kenneth W. Kizer, Under Secretary for Health (1994-1999).

COMMISSION ON CARE FINAL REPORT

- select the chief of VHA Care System (CVCS) and recommend the appointment of the CVCS to the President
- provide long-term, strategic direction for VHA Care System and establish priorities, milestones, and timelines
- oversee, direct, and make critical decisions regarding the transformation process
- review and approve major operational, business, and organizational plans
- set VHA Care System performance objectives and provide annual reports to Congress and the President on VHA Care System performance
- review and make decisions regarding VHA's budget request, and independently assess and report to Congress on the adequacy of VHA budgets

New governance and changes to assure continuity of leadership are critical to meeting the needs of VHA and veterans who depend on it. At the core of this foundational recommendation, the Commission calls for establishing a VHA board of directors,³⁵⁹ referred to as the VHA Care System governing board, which is independent of department leadership to provide governance, strategic direction, decision making, and oversight of VHA Care System's operations and transformation. Table 5 provides details regarding the governing board.

Table 5. Overview of VHA Care System Governing Board

Detailed Outline for VHA Care System Governing Board	
Voting Members	The President, the majority leader of the Senate, speaker of the House, the minority leaders of the Senate and House would each appoint two members. In addition, the SECVA would serve on the Board as a voting member.
Qualifications	Members would be selected to achieve collectively broad experience, expertise, and leadership, such as experience in senior management of large, private, integrated health care systems; clinical expertise; extensive experience with federal government health care systems; extensive experience with (though not current employment in) VHA; expertise in federal medical facility construction and leasing, and commercial property transactions; expertise in government contracting; expertise in federal health care budgeting and finance; expertise in health equity and disparities; and veterans' representation. Because of the importance of veterans' representation, at least one of each congressional leader's two appointees would be a veteran; at least one of the appointees of the President would be a veteran who receives VHA care.

³⁵⁹ Michael A. Froomkin, "Reinventing the Government Corporation," *University of Illinois Law Review*, (1995): 543, accessed June 15, 2016, <http://osaka.law.miami.edu/~froomkin/articles/reinvent.htm>. Congress need not create a government corporation to meet VHA's governance needs. The Commission notes that Congress has created entities it has called government corporations that are not predominantly commercial enterprises, rely on appropriations, and do not have the potential to become self-sustaining. A principal intention behind assigning this status and title has been to provide insulation from central management oversight agencies and the application of general management laws. When the corporation relies in whole or in part on appropriations, Congress retains the power of the purse, and the means of exercising it on matters large and small, and through formal and informal means.

Detailed Outline for VHA Care System Governing Board	
Terms	Governing board members would serve staggered terms of up to 7 years, with the governing board members electing a chair and vice chair from among the membership (other than the SECVA, who would not be eligible to serve as the chair) for 3-year terms.
Personnel Matters	Compensation would be at a rate equal to the daily equivalent of annual pay prescribed for level IV of the executive level. ³⁶⁰
Funding	Congress would provide a specific budget for the operation of the governing board as a separate account within VA's appropriations.
Relationship to the CVCS	Relationship to the CVCS: The governing board would provide the President its recommendation for a chief of VHA Care System (CVCS); the President would appoint that executive to a 5-year term; the governing board would annually review the CVCS's performance and be empowered to reappoint that official to a second 5-year term, to allow for continuity and to protect the CVCS from political transitions. The CVCS can be removed by mutual agreement of the President and the governing board.
Staff	The chairperson would determine the size and compensation of the permanent staff of the board, including an executive director responsible for governing board operations and a chief of staff. The director of the proposed transformation office within VHA would report to the chairperson through the CVCS.
Powers	<p>The board would have the power to do the following:</p> <ul style="list-style-type: none"> ▪ Select the CVCS and recommend the candidate to the President. ▪ Review the performance of the CVCS on an annual basis. ▪ Reappoint the CVCS to a second 5-year term. ▪ Remove the CVCS with the mutual agreement of the President. ▪ Direct and exercise decision-making authority regarding the transformation process and operations related to the transformation process. ▪ Establish priorities, milestones, and timelines for the transition process. ▪ Review and approve major new initiatives; major operational and organizational plans (including plans regarding capital asset and facility management); strategic and business plans; and goals and metrics for operational performance and established priorities. ▪ Oversee and manage facility and capital asset strategies and operations. ▪ Review, approve, and/or amend VHA's budget requests, and independently assess and comment on pertinent elements of the President's budget, as deemed appropriate.
Reporting	The board would report annually to the President and Congress on VHA's progress toward transformation.

Navigating transformation of one of the largest agencies in the federal government requires not only extraordinary leadership, but steady, sustained, long-range-focused governance. A governing board structured to provide continuity of membership—as the Commission proposes through staggered terms among members—is vital. A second critical step toward assuring such continuity would be to address the tenure of the CVCS and the process for selecting candidates for that position.³⁶¹ VHA, Congress, and the President would be better served by a VHA leader who holds a 5-year term of office, with the governing board empowered to reappoint that leader to a second 5-year term.

³⁶⁰ The rate of compensation provided for members of the Commission on Care.

³⁶¹ Under Secretary of Health, 38 U.S.C. § 305. Current law provides that the Under Secretary is appointed by the President with the advice and consent of the Senate. When a vacancy in that position occurs or is anticipated, the Secretary is to convene a commission (the composition of which is set forth in the statute) which is to recommend at least three individuals to the Secretary, who is to forward those names, with any comments the Secretary considers appropriate, to the President.

COMMISSION ON CARE FINAL REPORT

It is important that that the CVCS report to the board and function as a chief executive officer of VHA. Although the Commission envisions that the President would appoint this official, it is critical that the governing board be empowered to recommend to the President an individual for appointment when the office becomes vacant. This would replace the framework in current law that requires the establishment of a new commission convened solely to carry out the task of recommending candidates to the President.³⁶²

A governing board must be tailored to the unique needs of VHA.³⁶³ It should include members of appropriate expertise and experience to provide strategic guidance and continuity of leadership and it should possess authority to exercise the powers needed to realize and sustain a VHA transformation.³⁶⁴

Although some might consider Congress to be VA or VHA's board of directors and might question the appropriateness of establishing a VHA board of directors, this governance model does not diminish Congress's role. Instead, a board that would report periodically to congressional committees would provide a level of close oversight and health care expertise that would complement, and in many ways enhance, Congress's work.

A change in governance alone will not bring about successful transformation. This recommendation must be instituted in concert with many other Commission recommendations. For example, a board will require data, and data systems, to carry out its responsibilities, and establishing these and other appropriate systems, as addressed throughout this report, is key to empowering a board to drive and sustain transformation.

Implementation

Legislative Changes

- Amend 38 U.S.C., Chapter 3 to establish a VHA Care System governing board.
 - Amend 38 U.S.C. § 305—which currently provides in subsection (a) for the President to appoint the USH by and with the advice and consent of the Senate, and subsection (c) for the establishment of a commission to provide recommendations for appointees for USH when a vacancy is expected or has occurred—as follows:
 - Amend subsection (a) to provide for the President to appoint the CVCS to a 5-year term of office.
 - Repeal subsection (c) of that section.
 - Provide instead for the governing board to recommend a CVSC candidate.
 - Authorize the governing board to reappoint the CVSC to a second 5-year term.

VA Administrative Changes

- None required.

³⁶² Under Secretary of Health, 38 U.S.C. § 305.

³⁶³ Booz Allen Hamilton, *Veterans Health Administration (VHA) National Center for Patient Safety (NCPS) Systems Review: Final Report*, September 22, 2015, 60.

³⁶⁴ The Board is not an advisory body, and as such would not be subject to the Federal Advisory Committee Act.

Other Departments and Agency Administrative Changes

- None required.

Leadership

Recommendation #10: Require leaders at all levels of the organization to champion a focused, clear, benchmarked strategy to transform VHA culture and sustain staff engagement.

Problem

High-performing organizations have healthy cultures in which diverse staff members feel respected and engaged at work. These workers, in turn, are better able to demonstrate compassion and caring toward customers in their delivery of high-quality services. Leaders at all levels of the organization are responsible for promoting a positive organizational environment and culture through how they treat staff and the systematic approach they take to decision making and management. VHA has among the lowest scores in organizational health in government.³⁶⁵ For the past decade, VHA's executives have not emphasized the importance of leadership attention to cultural health, and it has not been well integrated in training, assessments, and performance accountability systems.

The Commission Recommends That . . .

- VHA create an integrated and sustainable cultural transformation by aligning all programs and activities around a single, benchmarked concept.
- VHA align leaders at all levels of the organization in support of the cultural transformation strategy and hold them accountable for this change.
- VHA establish a transformation office to drive progress of this transformation and report to the chief of the VHA Care System and the new VHA Care System governing board (also included in Recommendation #12).

Background

Healthy organizations successfully align, execute, and renew themselves through learning and innovation.³⁶⁶ They are characterized by a high level of trust, accountability, and ownership among staff; high functioning, empowered teams; and an environment that provides psychological safety and open communication, focuses on the needs of customers, and instills pride in performance.³⁶⁷ An inclusive workplace where diversity is valued, staff feel empowered and supported, are treated with fairness, and cooperation and open communication helps engage employees and drive organizational performance.³⁶⁸ Engaged

³⁶⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 56, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁶⁶ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁶⁷ [http://organizationalhealth.vssc.med.va.gov/Resource percent20Library/Forms/AllItems.aspx](http://organizationalhealth.vssc.med.va.gov/Resource%20Library/Forms/AllItems.aspx)

³⁶⁸ "Diversity & Inclusion; Federal Workforce At-A-Glance," U.S. Office of Personnel Management, accessed May 13, 2016, <https://www.opm.gov/policy-data-oversight/diversity-and-inclusion/federal-workforce-at-a-glance/>.

COMMISSION ON CARE FINAL REPORT

employees who are dedicated to their work and attached to the organization and its mission support a healthy organization.³⁶⁹

Companies that have a healthy organizational culture or engaged staff outperform those that do not. Companies that score in the top 25 percent of organizational health metrics outperform comparable companies in the bottom 25 percent by more than two-fold.³⁷⁰ Similarly, high employee engagement is correlated with better staff and customer experiences that include higher patient satisfaction, higher staff retention, better safety and quality, higher productivity and lower absenteeism.³⁷¹ Companies with engaged employees outperform those without by more than 200 percent.³⁷² Leaders and supervisors play a key role in establishing and sustaining employee engagement and in establishing a positive environment and culture that supports a healthy organization.³⁷³

Analysis

VHA staff and leaders are highly dedicated to the mission of VA and to serving veterans.³⁷⁴ This dedication is arguably VHA's greatest strength, and it can be leveraged to create and sustain positive change.³⁷⁵ There are substantial impediments to moving VHA forward, however, as noted in the *Independent Assessment Report*. There is a pervasive lack of trust throughout the organization.³⁷⁶ Staff perceives VHA to be bureaucratic and political and to lack a systems orientation.³⁷⁷ Employees want to work for an organization that is accountable and efficient, but instead they operate in a bureaucratic, siloed, and political organization.³⁷⁸ The culture creates risk aversion in staff, and when cultural factors are measured in VHA, none of the metrics align with the definition of a healthy organization.³⁷⁹ Staff find the work environment at VA challenging, with no connection to leadership, and feel they receive little positive

³⁶⁹ U.S. Office of Personnel Management, *Strategic Plan FY2014-2018: Recruit, Retain, and Honor*, 22, accessed January 25, 2016, <https://www.opm.gov/about-us/budget-performance/strategic-plans/2014-2018-strategic-plan.pdf>. Office of Management and Budget, *Memorandum for Heads of Executive Departments and Agencies: Strengthening Employee Engagement and Organizational Performance*, M-15-04, December 23, 2014, accessed May 16, 2016, <https://www.whitehouse.gov/sites/default/files/omb/memoranda/2015/m-15-04.pdf>.

³⁷⁰ "Organizational Health: The Ultimate Competitive Advantage," Scott Keller and Colin Price, McKinsey Quarterly, June 2011, accessed June 9, 2016, <http://www.mckinsey.com/business-functions/organization/our-insights/organizational-health-the-ultimate-competitive-advantage>.

³⁷¹ U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Melissa Bottrell, *Ethics Quality Helps Build Healthy Organizations*, VHA Organizational Health, Volume 19, Summer 2013, 4-5, accessed January 25, 2016, http://www.ethics.va.gov/docs/integratedethics/art_bottrell_orghealth_v19_2013.pdf.

³⁷² U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015, 4. Dee Ramsel, Improving VHA's Culture: A Presentation Before the National Leadership Council, Veterans Health Administration, December 2015, 7-9. U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 6, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁷³ Dee Ramsel, "Improving VHA's Culture. A Presentation Before the National Leadership Council, Veterans Health Administration," December 2015, 7-9.

³⁷⁴ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 43, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

³⁷⁵ *Ibid.*, 44.

³⁷⁶ *Ibid.*, 47.

³⁷⁷ *Ibid.*, 46.

³⁷⁸ *Ibid.*, 46.

³⁷⁹ *Ibid.*, 49-51.

reinforcement or clear feedback on performance.³⁸⁰ As demonstrated in the Federal Employee Viewpoint Survey for 2015, VHA staff does not believe top leaders lead (only 47 percent positive³⁸¹) and only 65 percent have a positive view of their immediate supervisor compared to 70 percent in other large federal agencies.³⁸²

Through the review of available documents and briefings from key staff, the Commission found VA and VHA have a number of activities intended to support a positive environment and culture in VHA (see Table 6), but the efforts are not systematic, integrated, or broadly deployed.³⁸³ The efforts are under-resourced to achieve success. Specifically, the effort lacks mandatory positions at the facilities to lead these efforts and has no requirements on the VHA Central Office (VHACO) program offices to participate in the efforts.³⁸⁴ At the same time, the efforts are duplicative in that multiple offices communicate similar, but distinct messages to field staff and leaders. VHA appears to lack systematic mechanisms to ensure leaders at all levels of the organization have the knowledge, skills, and ability to create an effective culture; metrics are not comprehensive or aligned with a single-change model; and leaders in VHACO and the field are not consistently held accountable for their actions in support of a positive organizational culture.³⁸⁵

*Table 6. Cultural Transformation Efforts in VA and VHA*³⁸⁶

Program/Initiative	Responsible Office
Servant Leadership	VHA National Center for Organizational Development
Leaders Developing Leaders	MyVA
Just Culture	VHA National Center for Patient Safety
Civility, Respect, and Engagement in the Workplace (CREW)	VHA National Center for Organizational Development
Organizational Transformation Pilot	MyVA
Employee Engagement Playbooks	MyVA
VHA Voices	VHA Office of Patient Centered Care and Cultural Transformation

³⁸⁰ Ibid., 53 and 60.

³⁸¹ U.S. Office of Personnel Management, *2015 Federal Employee Viewpoint Survey: Employees Influencing Change*, 47, accessed May 16, 2016, https://www.fedview.opm.gov/2015FILES/2015_FEVS_Gwide_Final_Report.PDF.

³⁸² Ibid.

³⁸³ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31. Dee Ramsel, Virginia Ashby Sharpe, Veterans Health Administration, conference call with staff of the Commission on Care, November 9, 2015.

³⁸⁴ See “Ethical Leadership, Fostering an Ethical Environment and Culture,” National Center for Ethics in Health Care, U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.ethics.va.gov/integratedethics/elc.asp>. “Stop the Line for Patient Safety Initiative,” U.S. Department of Veterans Affairs, accessed June 22, 2016, <http://www.qualityandsafety.va.gov/StoptheLine/StoptheLine.asp>. “VHA Center for Organizational Development,” U.S. Department of Veterans Affairs, accessed from VA Intranet, May 16, 2016, http://vaww.va.gov/NCOD/Organizational_Health.asp. U.S. Department of Veterans Affairs, MyVA: Putting Veterans First, *Employee Engagement Handbook: A Guide for Frontline Leaders to Measure and Drive Engagement*, September 2015.

³⁸⁵ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 13-14. Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan, Network Director and Medical Center Director*, November 20, 2015.

³⁸⁶ Dee Ramsel, “Improving VHA’s Culture. A Presentation Before the National Leadership Council, Veterans Health Administration,” December 2015, 29-31.

COMMISSION ON CARE FINAL REPORT

VHA must rebuild a high-performing, healthy culture by cultivating greater employee collaboration, ownership, and accountability to accomplish its mission.³⁸⁷ This cultural transformation needs to occur at all levels of the organization (VA, VHACO, veterans integrated service network [VISN], VA medical center, and community-based outpatient clinic). To achieve transformation in VHA, create a healthy environment and culture, and sustain staff engagement, the solution must start with leaders. Leaders must understand and believe in the powerful effect they have on the climate and culture in their organization. Change occurs one employee at a time. Leaders at all levels must commit to this change process. They must be inspired by top executives and embrace the values and mission of VHA and then, in turn, inspire their teams, engaging with individual employees to make change. Leaders must be given the roadmap and tools to make such change and then be supported with training, coaching, and feedback to achieve success. They must also be held accountable for their personal behavior and for the actions they take to positively influence the environment and culture of their unit or facility. Leaders should not be on their own in this transformation. Fellow leaders, outside experts, national program offices, and VA and VHA top executives must provide them with incentives, support, feedback, coaching, and, when needed, admonishment to support this cultural transformation.

To align leaders at all levels with expectations for the cultural transformation, all leaders must understand the role they play in the process. VHA must create standards for the behavior and actions leaders adopt to accomplish the transformation and widely publicize the standards among leaders and staff to establish uniform expectations across the organization and a single vision of cultural transformation. The CVCS and other senior leaders must model and reinforce these behaviors to further embed expectations. These behaviors and actions should be integrated into leadership assessment tools such as a 360 evaluation, performance management frameworks, and coaching guides to ensure expected behaviors and actions are reinforced across the leadership development and advancement system. The strategy must include the development of tools, training, guidelines, and operating procedures that create a living curriculum to support leaders in developing and deploying these new skills and behaviors. Finally, to ensure leaders at all levels implement the behaviors and actions, the strategy must establish both explicit rewards and sanctions. The rewards and recognition (nonmonetary) should liberally acknowledge and publicize leaders and staff who embody the very best standards of behaviors and actions that support a positive organizational culture. At the same time, leaders and staff at all levels must clearly understand what behavior and actions are not acceptable and be held accountable through disciplinary action if they cross these boundaries. Expectations and repercussions should be clearly articulated.

VA and VHA have a number of competing models of organizational health and staff engagement. The models are not integrated with one another or with an overall leadership competency model. Some models are robust, coupling abundant resources and training, while others are not. To create a clear focus for engagement and organizational health and guide

³⁸⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 55 accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

transformation effectively, one model must be selected for use in VHA. To do so, VHA must establish a cross functional executive team to make this decision. The team should include all of the stakeholder offices involved in current efforts, but none of them should lead the effort, to avoid parochial interests driving decisions. Once a single model is selected, the executive team must then outline a clear strategy, involving and engaging the offices in VHA with relevant expertise and resources to support the execution, and put forward a single strategic plan. Consequently, each of those offices must also be required to stand down its own efforts that are not part of this new model going forward and align its work and budget behind a single focused model and strategy. Tools, training, and communication to support broad deployment must be part of the strategy, and the CVCS and the executive team must present a compelling, transparent rationale for what the model is, why it was selected, and how it is to be deployed. All leaders and staff members in the organization must understand their roles in cultural transformation and what is expected of them.

The strategy must establish and articulate a clear set of behaviors and actions expected of staff to ensure their alignment around the transformation. The standards should be incorporated into the hiring process to ensure that VHA is hiring into the new culture and avoids a poor fit from the start. These behavioral expectations must be articulated clearly in the on-boarding process and reinforced on an ongoing basis in performance evaluations, reviews, and individual development plans. Leaders at all levels of the organization must also reinforce these behavioral expectations with staff and be provided with tools, messages, and communication support to accomplish this. Leaders must also recognize and reward the positive examples of the desired behaviors and sanction the worst examples, up to and including discipline and removal.

The change strategy should also recognize that cultural transformation and staff engagement go beyond individual leader and staff behaviors. Systems and processes at both the local and national level can impede the realization of the positive organizational culture desired. As such, the transformation strategy must also anticipate changing systems and processes as an explicit component of transformation. Leaders at all levels must establish mechanisms to elicit staff concerns and have quality improvement tools in place to address them, such as LEAN Six Sigma. Line staff must be engaged as part of the solution to these system issues. Leaders should be transparent about these issues and publicly track and report on progress.

To ensure the effective execution of this strategy, specific responsibilities must be assigned to program offices. The program offices must also support the VISN and facilities in their transformation effort by developing the standards and guidance for them to use and making program office expertise available to support coordination, coaching, and sharing of best practices across the institution. The program offices must be held accountable for supporting the application of these same standards and process within VHACO.

Standards for facility implementation must include a funded, full-time equivalent employee to support each major facility director³⁸⁸ and be the point person to coordinate efforts with VHACO and other facilities. Facilities may take the opportunity to consolidate related functions that currently exist in the facility. Each facility must have a local mechanism, such as an organizational health council, to integrate and drive transformation locally. But this does not

³⁸⁸ This equates to one person at each of the approximately 141 VHA health care systems led by a facility director.

COMMISSION ON CARE FINAL REPORT

mean the facility should create yet another committee or oversight group to accomplish the transformation. Instead, facilities must look to existing leadership structures and activities, consolidating similar efforts to create an efficient process.

Finally, the executive team must oversee the development of a consolidated and meaningful set of metrics, using community standards where available, to track cultural transformation, organizational health and staff engagement. The metrics should not only measure the desired outcomes but also provide insights to leaders on how to fix problems by providing sufficient detail and specificity to offer this insight. Once deployed, the metrics should be used by the executive team and responsible program offices to identify under-performing facilities and to provide additional expertise, resources, and support to help those facilities improve. If, after much support, the continuing behavior and actions of the leaders at the under-performing facility are identified as the cause of the long-term culture problem, these individuals must be removed from leadership positions in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Develop and implement a strategy for cultural transformation.
- Establish a cross-functional senior executive team reporting directly to the CVCS with long-term responsibility for creating, executing, and tracking the cultural transformation.
- Align frontline staff in support of the cultural transformation strategy.
- Require standards and a strategy for execution of the cultural transformation from every program office and facility and these efforts must be fully funded.
- Develop consolidated, meaningful metrics for organizational health and staff engagements with input from experts and field users.

Other Department and Agency Administrative Changes

- None required.

Recommendation #11: Rebuild a system for leadership succession based on a benchmarked health care competency model that is consistently applied to recruitment, development, and advancement within the leadership pipeline.

Problem

VHA, like any large organization, requires excellent leaders to succeed. Succession planning and robust structured programs to recruit, retain, develop, and advance high potential staff are essential to maintaining a pipeline of new leaders. In health care, leadership programs must prepare candidates with the specialized knowledge and skills required of health care executives, while also helping to mature their leadership traits. VHA does not use a single leadership competency model, and what it does use is not specific to health care or benchmarked to the private sector. VHA also does not use competency models as a tool to establish standards for hiring, assessment, and promotion. As a result, executive leaders and promising staff members do not have the tools they need to guide career transitions and ensure VHA has the leaders it needs for the future.

The Commission Recommends That . . .

- VA establish, as an Office of Management and Budget management priority for VHA, the goal of implementing an effective leadership management system in the agency.
- VHA executives prioritize the leadership system for funding, strategic planning, and investment of their own time and attention.
- VHA adopt and implement a comprehensive system for leadership development and management that includes a strategic priority of diversity and inclusion.
- Congress create more opportunities to attract outside leaders and experts to serve in VHA through new and expanded authority for temporary rotations and direct hiring of health care management training graduates, senior military treatment facility leaders, and private not-for-profit and for-profit health care leaders and technical experts.

Background

*Our Corps does two things for America: We make Marines and we win our nation's battles. Our ability to successfully accomplish the latter depends upon how well we do the former.*³⁸⁹

Effective leaders are required for organizational success. Thus, attracting, growing, and advancing leaders is a key business imperative across all sectors.³⁹⁰ The most urgent human capital management need worldwide, according to one survey, is the development of leadership talent.³⁹¹ This need is driven by a changing workforce that is motivated more by passion than by monetary incentives, a rapid advance in knowledge that quickly creates obsolescence, and technology drivers that change business practices over months instead of years.³⁹² Investing in new supervisors and emerging leaders is critically important because

³⁸⁹ U.S. Marine Corps, *Sustaining the Transformation*, Foreword, accessed June 9, 2016, [http://www.marines.mil/Portals/59/Publications/MCRP percent206-11D percent20Sustaining percent20the percent20Transformation.pdf](http://www.marines.mil/Portals/59/Publications/MCRP%20206-11D%20Sustaining%20the%20Transformation.pdf).

³⁹⁰ Jim Collins, *Good to Great: Why Some Companies Make the Leap . . . And Others Don't* (New York, NY: HarperCollins Publishers, Inc., 2001), 17-40. Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015).

³⁹¹ Deloitte Consulting LLP and Bersin by Deloitte, *Global Human Capital Trends 2014: Engaging the 21st Century Workforce*, 25, accessed June 10, 2016, http://dupress.com/wp-content/uploads/2014/04/GlobalHumanCapitalTrends_2014.pdf.

³⁹² *Ibid.*, 3.

COMMISSION ON CARE FINAL REPORT

employees report that when they quit a job they leave their supervisors and not their organization.³⁹³ In an organization like VHA, with more than 300,000 employees but only a bit more than 200 executives, VHA's 28,000 supervisors are responsible for leading the staff.³⁹⁴

Going back to at least 1998, the federal civilian sector has had difficulty identifying and promoting individuals with leadership skills.³⁹⁵ Staff members who can produce results and meet organizational objectives are promoted into supervisory and leadership positions.³⁹⁶ Yet, the skills needed to be a successful leader are different than those needed to be a successful technical expert. Today, soft skills such as empathy, effective listening, and team coaching are valued in leaders.³⁹⁷ The most effective leaders are those who consistently display integrity, high moral character, and the ability to inspire others.³⁹⁸ An effective leadership system develops leaders at all levels, from frontline supervisor to executives, and does so in all dimensions of leadership: "knowing, doing, and being."³⁹⁹

Analysis

In a review of VHA's approach to leadership development, the *Independent Assessment Report* noted the current system was not sufficient to meet VHA's need for high-quality, prepared leaders.⁴⁰⁰ VHA lacks a comprehensive approach to leadership development that would include formal structured programs such as networking, reflection, goal setting, learning, mentoring, experiential learning, and a clear career ladder. As a result, leaders are unable to fully prepare

³⁹³ "People Leave Managers, Not Companies," Victor Lipman, accessed June 10, 2016, <http://www.forbes.com/sites/#/sites/victorlipman/2015/08/04/people-leave-managers-not-companies/#78b15df216f3>.

³⁹⁴ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 21-23, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

³⁹⁵ U.S. Merit Systems Protection Board, Office of Policy and Evaluation Perspectives, *Federal Supervisors and Strategic Human Resources Management*, accessed June 10, 2016, <http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=280538&version=280868&application=ACROBAT>.

³⁹⁶ Ibid. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁷ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. "Creating and Retaining Great Leaders," Dominique Jones, accessed June 10, 2016, <http://www.hrreview.co.uk/analysis/analysis-hr-news/dominique-jones-creating-and-retaining-great-leaders/60419>. "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>.

³⁹⁸ Fred Kiel, *Return on Character: The Real Reason Leaders and Their Companies Win* (Boston, MA: Harvard Business Review Press, 2015). "The One Leadership Skill That Impacts Overall Success," Lydia Dishman, accessed June 10, 2016, <http://www.fastcompany.com/3056176/hit-the-ground-running/the-one-leadership-skill-that-impacts-overall-success>. Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title.

³⁹⁹ Sherry Heffner et al., *Develop Your Leaders, Transform Your Organization*, accessed June 10, 2016, http://www.harvardbusiness.org/sites/default/files/16843_CL_Whitepaper_Transform_Organization_0.pdf?trk=profile_certification_title. U.S. Marine Corps, *Sustaining the Transformation*, accessed June 9, 2016, http://www.marines.mil/Portals/59/Publications/MCRP_percent206-11D_percent20Sustaining_percent20the_percent20Transformation.pdf.

⁴⁰⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

for future roles.⁴⁰¹ Although VHA does have some components of a development program, the activities are not connected to a career path and not well coordinated. Comprehensive development efforts are impeded by the use of multiple competing competency models in VA that make it impossible to align assessment and development with a cohesive standard. Emerging leaders are left to navigate career progression largely on their own and may be stymied because development opportunities are cancelled due to budget restrictions. Even when promising young leaders complete the current activities, gaps remain in their experience and training because the training programs are not coordinated.⁴⁰² As a result, VHA does not have a robust pipeline of young leaders ready to take on higher-level responsibilities.⁴⁰³

Included in the *Independent Assessment Report* is a recommendation that VA stabilize, grow, and empower leaders. This recommendation includes suggestions to fill current vacancies with high-quality leaders, improve the attractiveness of the roles, ensure leaders are prepared to assume their roles, and create a comprehensive strategy that connects top performers to leadership opportunities and development plans.

There is little concrete information in the assessment to suggest how VA and VHA should accomplish these objectives. The commission examined VA's and VHA's current work to assess whether they have created plans to operationalize the leadership development recommendations articulated in the *Independent Assessment Report*.

Neither VA nor VHA has rationalized the multiple competency models within the department. A competency model is the core driver informing recruitment, development, assessment, and advancement in any comprehensive approach to leadership development and management.⁴⁰⁴ Having a cogent competency model is a prerequisite to a coherent strategy.⁴⁰⁵ Leading a health care organization requires specialized knowledge and skills not required of leaders in other fields.⁴⁰⁶ Thus, any competency model applied in VHA must include health care specific components. Health care executive competencies embrace such topics as an understanding of ethics in health care, management of self-governing professionals (e.g., physicians, nurses), the technical knowledge of health care regulation and operational management, and leading change, in addition to other leadership skills and knowledge.⁴⁰⁷

The current models used in VHA do not reference external benchmarks, and they are not health care specific. VHA plans to continue to use the High Performance Development Model (HPDM) as its competency model.⁴⁰⁸ HPDM was developed by VHA and is not benchmarked to private-sector competency models for health care executives. VHA plans to use the model to drive

⁴⁰¹ Ibid.

⁴⁰² Ibid., 38.

⁴⁰³ Ibid., 37.

⁴⁰⁴ The American College of Healthcare Executives, *ACHE Healthcare Executive: 2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf.

⁴⁰⁵ Ibid.

⁴⁰⁶ Ibid.

⁴⁰⁷ Ibid. "Joint Medical Executive Skills," Joint Medical Executive Skills Program, U.S. Department of Defense, accessed May 16, 2016, http://www.au.af.mil/au/awc/awcgate/leadership/med_exec_skills.htm. "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁰⁸ "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

COMMISSION ON CARE FINAL REPORT

position requirements, performance management, and training content.⁴⁰⁹ The plan mentions coordination with VA Learning University but provides no detail.⁴¹⁰ The plan also does not provide specific information about how the use of HPDM will link to formal recruitment, performance assessment, and advancement of leaders.⁴¹¹

VHA is working to understand the current career progression of candidates who move into field-based executive positions. VHA field leaders are cultivated from within VHA with about 98 percent advancing from lower-level field positions such as associate director, service chief, or chief of staff.⁴¹² As a result, field senior executives often lack outside experience and first-hand knowledge of alternative management methods.⁴¹³ Most companies look for a mix of internal and external hires, and the circumstances of the organization often drive the mix.⁴¹⁴ For instance, Henry Ford Health System, a successful growing company with a robust internal leadership development program has set a target of 70 percent internal promotions and 30 percent external hires.⁴¹⁵

The VHA pool of internal candidates is also deficient in racial and ethnic diversity with striking under-representation of women of color in all of the positions that constitute the pipeline for medical center director positions (see Figures 6 and 7).⁴¹⁶ VHA leadership development programs have failed to effectively recruit and advance under-represented minorities with a striking over-representation of White men in the leadership class that feeds the senior executive service (see Table 7).⁴¹⁷ Minority women shoulder the biggest burden of formal mentoring within the organization.⁴¹⁸ VHA also has the lowest representation of veterans among its staff (31 percent) compared to Veterans Benefit Administration (52 percent) and National Cemetery Administration (74 percent). The number of veterans among doctors and dentists in VHA is only about 14 percent of the employees.⁴¹⁹ Among leaders, 22 percent of senior executives are veterans and a similar number (23.8 percent) populate the leadership pipeline.⁴²⁰

⁴⁰⁹ Ibid.

⁴¹⁰ Ibid.

⁴¹¹ Ibid.

⁴¹² Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹³ Ibid.

⁴¹⁴ Eric Krell, "Staffing Management: Look Outside or Seek Within?" *HR Magazine*, January/February 2015.

⁴¹⁵ "NCHL Health Leadership Competency Model," National Center for Healthcare Leadership, accessed May 16, 2016, <http://www.nchl.org/static.asp?path=2852,3238>.

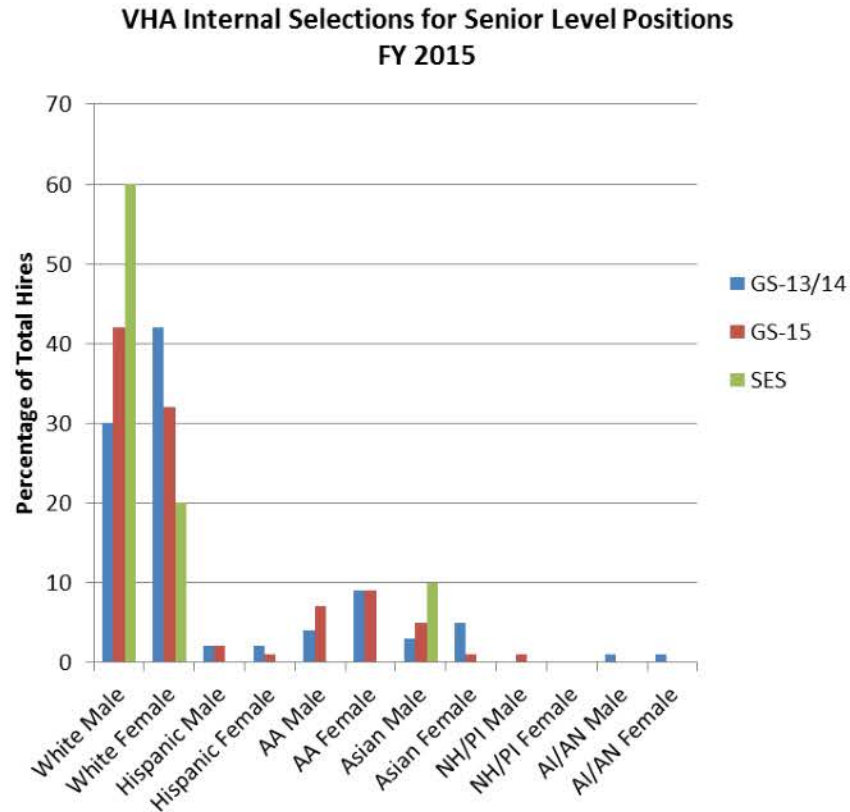
⁴¹⁶ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

⁴¹⁷ Under Secretary for Health, Veterans Health Administration, *Federal Equal Opportunity Recruitment Program (FEORP) Report FY2015 Accomplishment Report and FEORP FY2016 Plan Certification, Attachment A*, November 23, 2015.

⁴¹⁸ Ibid.

⁴¹⁹ Health Care Talent Management Office from PAID and NOA, September 17, 2015: Path to Medical Center Director, Healthcare Leadership Talent Institute.

⁴²⁰ VHA Health Care Talent Management Office, provided to Commission on Care for employees in VHA as of September 30, 2015 by request, March 8, 2016.

Figure 6. Diversity of Senior-Level Hires in VHA

AA = African American

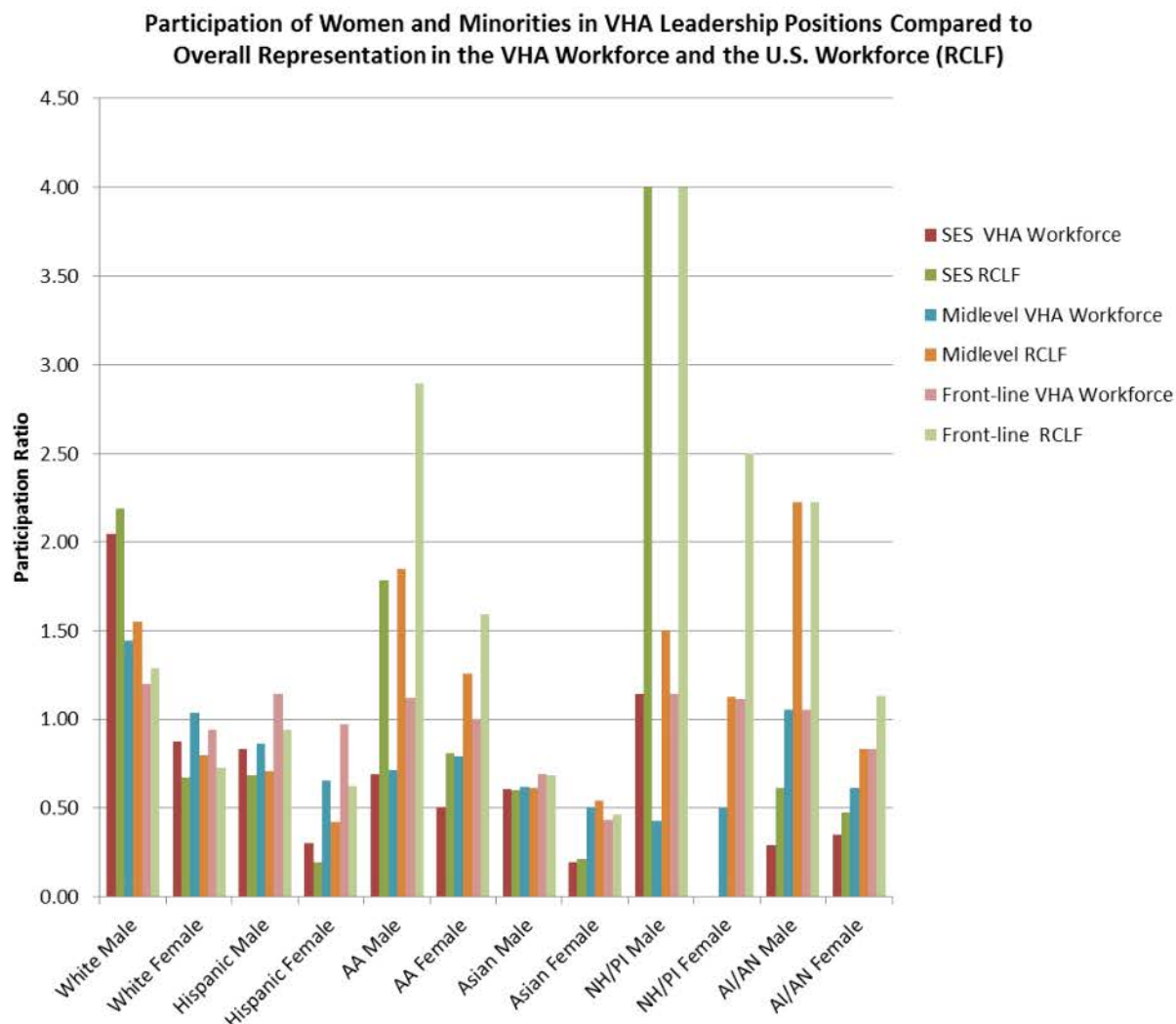
NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: In FY 2015, VHA failed to select many candidates from diverse racial and ethnic backgrounds for senior executive positions. These data were drawn from the VHA annual equal employment opportunity (EEO) report.

COMMISSION ON CARE FINAL REPORT

Figure 7. Minority Women are Under Represented in Higher-Level Positions in VHA



AA = African American

NH/PI = Native Hawaiian/Pacific Islander

AI/AN = American Indian/Alaska Native

Note: Women and particularly minority women are under-represented in comparison to their participation in the U.S. workforce (relevant civilian labor force [RCLF]) and their participation in the VHA workforce at higher levels in the organization. Some minority men are also under-represented in high-level positions. These data were derived from the VHA annual EEO report.

Table 7. White Males are Over Represented in VHA SES Development Program, HCLDP

	TCF 2015 (N)	GHATP 2014 (N)	Facility LEAD 2015 (N)	VISN/CO LEAD 2015 (N)	HCLDP 2015 (N)	VHA Workforce
White Male	35% (78)	30% (14)	19% (160)	22% (69)	41% (151)	23%
White Female	16% (35)	28% (13)	41% (342)	41% (127)	39% (144)	36%
African American Male	15% (33)	9% (4)	8% (66)	8% (24)	4% (14)	9%
African American Female	19% (42)	15% (7)	22% (180)	16% (50)	6% (23)	15%
Hispanic/Latino Male	4% (10)	4% (2)	3% (23)	4% (11)	1% (5)	3%
Hispanic/Latina Female	3% (7)	2% (1)	3% (29)	3% (10)	1% (4)	4%
Asian Male	4% (9)	2% (1)	1% (9)	>1% (2)	2% (7)	3%
Asian Female	2% (5)	9% (4)	2% (16)	4% (13)	3% (12)	5%
Native Hawaiian/Pacific Islander Male	0% (0)	0% (0)	>1% (3)	0% (0)	0% (0)	>1%
Native Hawaiian/Pacific Islander Female	0% (0)	0% (0)	0% (0)	0% (0)	0% (0)	>1%
American Indian/Alaska Native Male	2% (4)	0% (0)	>1% (1)	>1% (2)	1% (3)	1%
American Indian/Alaska Native Female	0% (0)	0% (0)	1% (7)	1% (4)	1% (3)	1%

Note: VHA offers career development opportunities from entry-level programs (TCF and GHATP) to an SES preparatory curriculum (HCLDP). Overall, White men make up about 23% of VHA employees but are over-represented in the HCLDP program at 41%. African American and Hispanic men and women are under-represented in the same program. TCF= Technical Career Field; GHATP=Graduate Healthcare Administration Training Program; LEAD=Leadership, Effectiveness, Accountability, and Development; HCLDP=Health Care Leadership Development Program.

No evidence was presented to indicate that career progression mapping is occurring for positions within VHA central office, where high-quality leaders are also required.⁴²¹

⁴²¹ Department of Veterans Affairs, Veterans Health Administration, *VHA Workforce Planning Report 2015*, 94, accessed June 10, 2016, http://vaww.succession.va.gov/Workforce_Planning/WorkforcePlanningLibrary/2015%20VHA%20Workforce%20Report.pdf.

COMMISSION ON CARE FINAL REPORT

VHA has much work to do to produce an effective leadership management system. Recruitment, retention, development and advancement are key processes that require immediate and sustained attention from VHA leaders. Without substantial changes, high-potential staff will continue to struggle to understand their career trajectory. Without a driving competency model and coordinated training to guide advancement, hiring decisions will continue to be made without uniform standards against which to measure applicants and new executive hires will continue to struggle to understand VHA and their role in leading it. Without the committed engagement and support of the chief of VHA Care System (CVCS) and the other top VHA executives for the leadership management system and their direct communications about and modeling of the leadership competencies, VHA will continue to flounder. As a result, veterans will be denied the high-performing health system they deserve.

Executive Commitment

The long-term success of any enterprise rests on having excellent leaders in key positions and sustaining them over time. To accomplish this goal, leadership management, development, and recruitment must be a core responsibility and a priority for VHA senior executives. To start, VA must include the goal of achieving an effective leadership management system in VHA as a component of the department's management agenda in the annual budget. The goal is a robust, high-quality, diverse leadership team in VHA. VA needs to establish a credible operational plan and accountability mechanisms for meeting this goal. Executive leaders are then held accountable for attaining the leadership management goals, including personally investing time in meeting diversity targets, recruitment plans, and succession planning objectives. These targets are to be reviewed in the individual performance of top leaders as well as in the Office of Management and Budget's ongoing review of the department's management objectives. Executive leaders need to also set and communicate clear expectations for the behavior of leaders and staff and to invest their own time in mentoring, coaching, and developing subordinate leaders and promising staff, including under-represented populations. They must be visible and role-model leadership competencies in meetings, training, and new-hire orientations. They must take an interest in developing leaders and help create opportunities for them to gain leadership experience and competencies. The CVCS and senior executives must keep in mind that their sole role is not to manage crises or to oversee a process or to manage up. Rather, their primary role is to lead their people. Their time and attention must reflect that priority.

Leadership Model

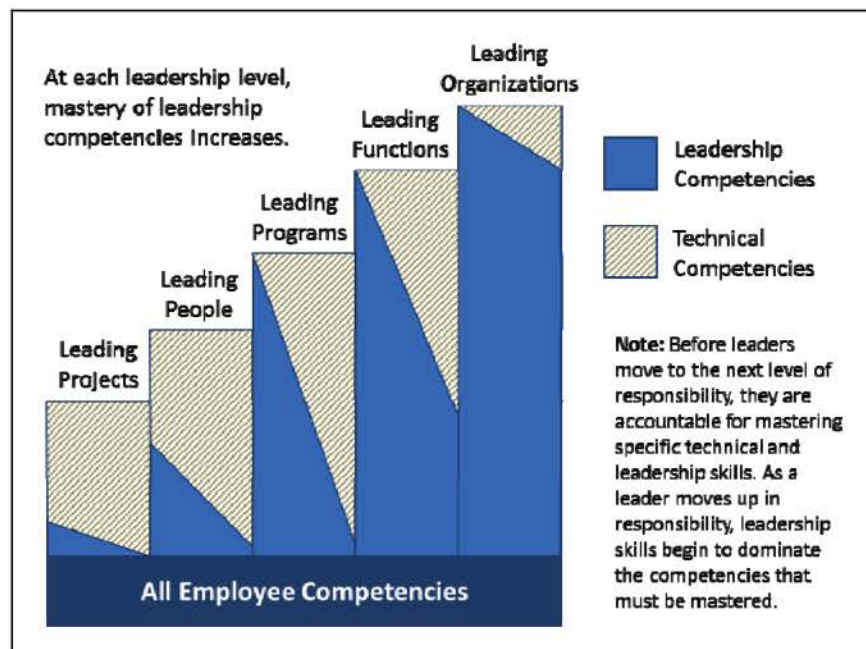
To establish clear leadership standards to guide hiring, development, and the advancement of leaders, VHA needs to adopt one benchmarked health care competency model. Currently, VHA is subject to the Office of Personnel Management executive core qualifications, HPDM, and standards for servant leadership. Although all of the models have value, none provide a clear trajectory for high-potential staff to follow, and they do not provide opportunities for VHA to intersect with leaders in the private sector. VHA must stop using these varied competency models and instead adopt a single model that is benchmarked to private-sector standards. The Commission is not making a recommendation about which model VHA should choose. Rather VHA should apply the criteria below to select a model around which to base its leadership development program:

- The standard must embrace leading through ethics and values, demonstrating character and concern for others, and creating a strong organizational culture.
- The standard must be health care based and describe the knowledge, skills, ability, and leadership bearing and behaviors that health care leaders must master to be effective.
- The standard must be a robust competency model including aligned training and tools to permit quick implementation.
- The model must describe different career tracks and the mastery requirements for key points in each career track. Key career tracks such as VISN director, facility director, and VHA Central Office (VHACO) program executive should fit into the competency model.
- A career path must specify the competencies that require mastery before moving to a higher position.
- VHA may need to enhance the model with competencies in care and services to Veterans and knowledge of military occupational health.

Training and Assessment

VHA needs to develop assessment tools based on the competency model, including 360, 180, self-assessment, and supervisory review processes. Leaders and developing leaders should be required to use at least one of the assessments each year and to apply the results to identifying their training and development needs. Findings from the assessments should be rolled into an individual development plan (IDP) for each leader or developing leader and enrollment in a leadership course should require a documented need from one of these assessments.

Figure 8. *At Each Leadership Level, Mastery of Leadership Competencies Increases*



COMMISSION ON CARE FINAL REPORT

Training must be mapped against the competency model career track. All current leadership training should be mapped against the model. Gaps should be identified and filled with commercially available, or where needed, internally developed training. This training should include leadership competencies for the care of veterans, including an understanding of military occupational health, combat injuries and exposure, combat readjustments, and military sexual trauma. (See Appendix H for descriptions of such training material.) VHA should look for opportunities to partner with Department of Defense and the private sector to provide joint training and development opportunities to fill some of the identified gaps. VHA must develop one or more face-to-face training series that allow high-potential candidates to complete all the competencies required to move to the next career stage. As VHA strengthens its partnership with community providers and health systems, executive and high-potential training resources from VHA should be made available to community health care leaders and VHA should join training offered by these private-sector partners.

Based on the benchmarked competency model, VHA should collaborate with Academic Affiliates to establish two new programs. The first is to create opportunities for VHA physicians to gain masters-level training in health care management to prepare them to lead a medical facility. Second, VHA should work to create rotations in VHA for external physicians who are completing graduate health care management programs. Like academic affiliate residency training programs, VHA should collaborate with academic medicine to establish, fund, and run these programs with the goal that all participants rotate in management positions in VHA or VHA-partnered private-sector systems for six or more months during their training. Graduates of such programs would be candidates for recruitment into the VHA leadership pipeline and would encumber a pay-back commitment to VHA for any direct funding provided.

All training should include formal assessment to assure that learners have mastered the material and this mastery should be noted in their IDPs and training record.

As part of the leadership development model, experiential learning opportunities and formal coaching are critical to executive learning. Individual and group coaching standards and programs must be established for all developing and new leaders. A program for senior leaders to pair them with private-sector health care leaders must also be supported. VHA must establish rotation opportunities for developing leaders to rotate for substantial periods (e.g., 3 to 18 months) in not-for-profit hospital systems. This program could be structured as a certificate program that the employee and VHA jointly fund and include a payback commitment on the part of the trainee. Similar rotations from the private sector into VHA should be developed with health care system partners to help develop private-sector competencies in care for veterans and inject private-sector approaches into VHA.

Apply the Leadership Model

VHA is required to apply the competency model in all hiring decisions for executive career field positions. Thus all functional statements must be based on the model, all interview protocols must incorporate the competencies, and all candidates who are not internally certified to the standard of the job must undergo an assessment by a board to ensure they meet the position requirements. Conversely, internal candidates must be required to demonstrate mastery of the competencies before qualifying to apply for a position. VHA must adopt the strategies of executive recruiters to identify and recruit needed experts outside of government with the

competencies VHA seeks. Recruiters can look to the pipelines the Commission has recommended building to bring military treatment facility commanders and other senior leaders and private sector experts into VHA as a network for identifying additional recruits. Executive recruiters can particularly help ensure diverse candidates are identified for open positions.

VHA will require competency assessments and IDPs for all existing executives, potential executives, and new hires. Current leaders and new hires who have an identified gap in any competency must have it included in their IDP and be required to fill these deficiencies by a specific deadline or face demotion or dismissal. Completion of IDP development opportunities is required for advancement in grade or promotion to higher position within the leadership pipeline.

VHA will aggressively manage its leadership candidate pool by identifying and tracking all high-potential individuals. Diversity statistics should be tracked and diversity in this pool actively managed. This pool of candidates derives from annual ratings as well as leadership development program graduates. Supervisors and executive leaders must provide ongoing coaching for higher positions to this pool of developing leaders. VHA must identify anticipated succession needs and offer development opportunities that would help prepare candidates for these anticipated openings. Once the positions are open, individuals in the high-potential pool must receive notices of new job postings and detail opportunities that provide experience into higher positions. Candidates who agree to be in this pool should be required to enter into formal mentoring relationships with leaders outside their chain of command to further advance their career development. For highest-level positions (VISN director, facility director, VHACO chief officer) a formal pool of approved or precertified candidates should be established.

To expand the perspectives and management experience in its leadership pipeline, VHA must develop explicit strategies to on-ramp diverse candidates at critical midcareer transition points. This process includes creating pathways for retiring commanders and other senior officers of military treatment facilities to compete effectively for leadership positions in VHA. To increase VHA understanding of private-sector health care, VHA must develop midcareer entry points for private-sector candidates. This could be accomplished through the use of temporary hiring authority and the ability to convert these positions to permanent staff positions if leadership competencies standards have been met by the candidates. Such opportunities can be modeled on efforts recently announced by DoD and, wherever practicable, should be developed collaboratively with DoD to establish the legal and policy requirements for implementing these programs. Finally, the current graduate health administration training program (GHATP) program should be expanded to include more schools and programs with diverse trainees. This expansion must allow high-performing residents to continue to convert to full time positions.

On-boarding

A formal on-boarding process should be instituted for all new executive hires. In addition to the transactional knowledge the individual will need, on boarding should establish the expectations for what it means for that executive to be successful in VHA. The values of the organization and the expectations for ethical practice must be conveyed by the CVCS and the top leadership team. A formal assessment of knowledge and skills should be made during on-boarding and an IDP established to cover the probationary period of new hires if any deficiencies are identified.

COMMISSION ON CARE FINAL REPORT

Completion of the IDP is required for continued employment. All new leadership hires should be assigned a coach based on their individual needs. Within their first 6 months of employment, the undersecretary for health and Secretary should meet with these new executives to build a relationship with them and hear their fresh perspectives on the performance of VHA.

Stabilize Leadership

VHA should immediately stabilize its leadership ranks by authorizing VA medical center and veterans integrated services network (VISN) director details to last up to a year with no restrictions on an acting leader competing for the permanent position. VHA should also create flexible capacity by creating more assistant-level positions (e.g., assistant director, assistant VISN chief medical officer, assistant nurse executive, deputy chief officer). These individuals would comprise the pool of potential leaders and also allow for cross filling positions that are empty due to development assignments, training, or other leadership development opportunities.

Implementation

Legislative Changes

- Establish direct-hire authority from the graduate health care administration training program, military treatment facility, and private-sector fellow pools, clarifying application of merit-system principles, including approaches to managing veterans' preference in these programs.
- Establish Intergovernmental Personnel Act authority for VHA to include the for-profit private sector; this could be done as a pilot program with a report to Congress before considering whether to make the authority permanent.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.
- Aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: All hires and promotions are required to demonstrate these competencies.
- Require a formal on-boarding process for HPDM 3 and 4 leaders at all levels that reinforces the leadership competency model.
- Take immediate steps to stabilize the continuity of leadership by extending the length of authorized details to extend the continuity of leadership at medical centers and allow leaders detailed to a position to compete for a permanent appointment to the position by removing the non-compete requirements.

COMMISSION RECOMMENDATIONS

- Establish the competency model in regulation and include requirements for its use in hiring, promotion and dismissal and clarify the application of veterans' preference in executive development.

Other Department and Agency Administrative Changes

- None required.

Recommendation #12: Transform organizational structures and management processes to ensure adherence to national VHA standards, while also promoting decision making at the lowest level of the organization, eliminating waste and redundancy, promoting innovation, and fostering the spread of best practices.

Problem

Leadership structures and processes should be organized to promote agile, clear decision making, the free flow of ideas, and identification of organizational priorities, as well as make clear reporting relationships and lines of accountability within the organization. VHA currently lacks effective national policies, a rational organizational structure, and clear role definitions that would support effective leadership of the organization. The responsibilities of VHA Central Office (VHACO) program offices are unclear, and their functions overlap or are duplicative. The role of the Veterans Integrated Service Network (VISN) is not clear, and the delegated responsibilities of the medical center director are not defined.

Background

A prerequisite of a successful, high-performing system is having strong leaders and a strong leadership system.⁴²² An organization's leadership system is "the way leadership is exercised, formally and informally, throughout the organization; the basis for key decisions and the way they are made, communicated, and carried out."⁴²³ It includes "structures and mechanisms for making decisions; ensuring two-way communication; selecting and developing leaders and managers; and reinforcing values, ethical behavior, directions, and performance expectations."⁴²⁴ In an organization the size of VHA, with a budget of \$69 billion,⁴²⁵ more than 300,000 employees, and more than 1,000 sites of care,⁴²⁶ strong leadership systems are essential.

The Commission Recommends That . . .

- VHA redesign VHA Central Office (VHACO) to create high-performing support functions that serve Veterans Integrated Service Networks (VISNs) and facilities in their delivery of veteran-centric care.
- VHA clarify and define the roles and responsibilities of the VISNs, facilities, and reorganized VHA program offices in relation to one another, and within national standards, push decision making down to the lowest executive level with policies, budget, and tools that support this change.
- VHA establish leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue, and collaboration.
- VHA establish a transformation office, reporting to the chief of VHA Care System with broad authority and a supporting budget to accomplish the transformation of VHA and manage the large-scale changes outlined throughout this report (also included in Recommendation #10).

⁴²² Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 50.

James Collins, *Good to Great: Why Some Companies Make the Leap and Others Don't*, (New York, NY: HarperCollins, 2001), 17-64.

⁴²³ Ibid.

⁴²⁴ Ibid.

⁴²⁵ Department of Veterans Affairs, *VA 2017 Budget Request: Fast Facts*, accessed March 10, 2016, <http://www.va.gov/budget/docs/summary/FY2017-FastFactsVAsBudgetHighlights.pdf>.

⁴²⁶ "About VHA," Department of Veterans Affairs, accessed February 5, 2016, <http://www.va.gov/health/aboutVHA.asp>.

In the last successful reorganization of VHA in 1995,⁴²⁷ the organizational design and functional roles of the leadership system were organized into clear structures with clear functions. The VISNs were responsible for operations⁴²⁸ and VHACO program offices were responsible for policy, guidelines, and outcomes.⁴²⁹ The National Leadership Board (made up of VISN directors and all program office leaders) was responsible for collective, fact-based decision making and the Friday Hotline call was used to communicate leadership priorities and decisions directly to VA medical center (VAMC) leadership. A negotiated performance measurement system based on consistent, benchmarked, outcome-focused metrics⁴³⁰ was also established that was supported by centralized functions that benefit from economies of scale.⁴³¹ As part of the reorganization, VHA experienced a reduction in staff and consolidation of VHACO offices to create a flat, agile leadership system.⁴³² Because this functional matrix was not sustained, VHA now faces the challenge of reinstituting an effective leadership system.

Analysis

Twenty years after the Kizer reorganization, VHA has a very different leadership system, under which it “is intensely, unnecessarily complex due to a lack of clear operating model, limited role clarity, fragmentation of authority, and overlapping responsibilities.”⁴³³ The *Independent Assessment Report* included the following findings about the VHA operating model:⁴³⁴

- VHACO has grown rapidly since 2009 from 753 in FY 2009 to 1,990 in FY 2014.
- The VISNs’ ability to manage and support their regions is heavily hampered by resourcing restrictions and direct VHACO control over VAMC operations.
- The VAMCs’ operating model suffers from powerful silos, which prevent an effective end-to-end mission focus.
- VA’s increasingly top-down management style, coupled with poor prioritization and the external political environment, result in a lack of clarity around strategic direction, reactivity to external headwinds, and flawed efforts to standardize.

VHACO has grown rapidly in the past few years.⁴³⁵ The growth in central office was driven in part by new ideas, new priorities, and new crises being addressed through the creation of new

⁴²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco, CA: Berrett-Koehler Publishers, Inc., 2012), 54.

⁴²⁸ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 35. Kizer, Kenneth W and Ashish Jha, “Restoring Trust in VA Health Care,” *New England Journal of Medicine*, 371, (2014): 295-297.

⁴²⁹ Ibid.

⁴³⁰ Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Vision for Change: A Plan to Restructure the Veterans Health Administration*, 1995, 61-72.

⁴³¹ Ibid., 33.

⁴³² Ibid., 60. Kenneth Kizer, Veterans Health Administration, Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation of the Veterans Healthcare System*, Objective 3 and 17, 1996.

⁴³³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 95, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴³⁴ Ibid.

⁴³⁵ Ibid., 98.

COMMISSION ON CARE FINAL REPORT

offices and new staff infrastructure to support it.⁴³⁶ A portion of the growth came from the centralization of functions that were previously managed in the field such as business office functions. The final component has come from the duplication in VHA of offices in which decision-making authority rests with VA, such as communications and regulatory management. VHA has also duplicated functions and responsibilities between two or more offices in VHA, such as primary care, surgery, mental health, and geriatrics and extended care. This increased growth in staff and offices has resulted in more complex and lengthy decision processes, often with little clarity as to whom ultimate responsibility for decisions or follow up falls.⁴³⁷

One symptom of the top-down management is VHACO control of budgeting and resource management. “Support funding is outside local control” and the “increasing share of Specific Purpose funding hinders” local leaders in their ability to use resources effectively.⁴³⁸ In FY 2015, specific-purpose funds were spread across more than 450 line items,⁴³⁹ taking money away from general purpose funding and restricting how this money can be used. Both VHACO and Congress have been complicit in taking control away from medical center directors through these budget controls.⁴⁴⁰ For instance, the congressional appropriation to fund VHA for 1998 included only five appropriation line items; medical care, medical administration, construction major, construction minor, and medical and prosthetic research.⁴⁴¹ In contrast, the budget request to Congress for FY 2016 included 12 budget categories relevant to VHA with some of those accounts having four or five subcategories.⁴⁴² In his testimony before the Commission and Congress, Secretary McDonald made the point that such fragmentation of the VHA budget and the prohibition to reallocate across budget categories without first receiving Congressional approval was an impediment to effective and agile management of the department.⁴⁴³ Greater Congressional control of VHA spending is understandable in light of VA’s lack of adequate management systems and data analytic capabilities to track expenditures in real time⁴⁴⁴ and report them to Congress and central office. The only means available to hold the medical centers

⁴³⁶ Ibid., 96-99.

⁴³⁷ Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 7-9.

⁴³⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴³⁹ Ibid., 107.

⁴⁴⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Assessment L (Leadership)*, 102-108, accessed June 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁴⁴¹ PL 105-65, October 27, 1997.

⁴⁴² Department of Veterans Affairs Fiscal Year 2016 Budget Submission, Volume II Medical Programs and Information Technology, Accessed June 10, 2016, <http://www.va.gov/budget/products.asp>.

⁴⁴³ On January 21, 2016, Secretary of Veterans Affairs, Robert A. McDonald, provided the following testimony before the U.S. Senate Committee on Veteran’s Affairs “Flexible Budget Authority: We need flexible budget authority to avoid artificial restrictions that impede our delivery of care and benefits to Veterans. Currently, there are over 70 line items in VA’s budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to Veterans. These include limitations within the same general areas, such as health care funds that cannot be spent on health care needs and funding that can be used for only one type of Care in the Community program, but not others. These restrictions limit the ability of VA to deliver Veterans with care and benefits based on demand, rather than specific funding lines.” accessed June 10, 2016,

<http://www.veterans.senate.gov/imo/media/doc/VA%20Sec%20Testimony%2001.21.2016.pdf>

⁴⁴⁴ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 105, accessed March 10, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

accountable was to fund the priority initiatives as separate budget lines or indicate allocations to be made under the specific-purpose process.

To fix the overly complex and bureaucratic structure of VHA, the *Independent Assessment Report* suggests that VHA “redesign (its) operating model to create clarity for decision-making authority, prioritization, and long-term support.”⁴⁴⁵ VHA must take a systems approach to reorient its leadership operations, restructuring and re-orienting VHACO program offices to ensure all of the following:⁴⁴⁶

- fact based, innovative decision making that is responsive to the field, other offices, and external stakeholder requirements
- feedback mechanisms to incorporate system learning into policy development and operational guidance
- communication mechanisms to effectively share information across offices and reach VISN and facilities to explain expectations and tie decisions to organizational values and goals
- effective execution of policy decisions through expert coaching, deployment of resources, and guidance based on external benchmarks and sharing of internal best practices
- analytic capability and infrastructure to effectively monitor progress and outcomes of all organizational priorities

Such a reorientation will involve a different skill set and expertise than currently required in VHACO. Transformation will call for recruiting new expertise, making advancement decisions based on these new competencies, reinforcing them through recognition and performance assessment, and developing new skills in current staff through training and coaching. This skill set includes a high level of technical expertise relevant to the program office; the ability to build relationships with external stakeholders; demonstrated skills in coaching, staff development, and training; certification in quality improvement methodologies; analytic capabilities to develop and track metrics; and the ability to lead transformational change. VHA must fully fund the retraining and the hiring of skilled staff in VHACO to accomplish this transformation.

For the VHACO program offices to work effectively with one another and with the field, the specific authority of each office must also be defined. Where overlap and confusion exists between offices, programs must be combined and streamlined or eliminated with a corresponding reduction in force. In changing the structure and orientation of VHACO program offices, VHA leadership can take the opportunity to align functions to achieve its stated priority of patient-centered care. In a fully aligned operating structure, business processes from the VAMC front line to central office must be organized to deliver important

⁴⁴⁵ Ibid., ix.

⁴⁴⁶ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, (Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology, 2015), 7, 34, and 50.

COMMISSION ON CARE FINAL REPORT

patient outcomes rather than aligned in professional silos. For instance, instead of having an office of nursing, one for social work, and a lead for physician assistants, business offices should be aligned around the work they do together, like patient aligned care teams, to deliver positive outcomes for veterans.

The administrative operations of VHACO should also be flattened. Senior staff should be speaking directly to other senior staff to discuss and make decisions rather than relying on bureaucratic, paper-based processes as a means of negotiation: It is neither a healthy culture nor an efficient process. At the same time, VHACO needs to take full advantage of being a large-scale enterprise by centralizing functions such as acquisition package development, recruitment package development, and account reconciliation so that staff is not required in each program office to take on these occasional but complex activities. The net savings resulting from this reorganization and delayering of the bureaucracy must be reinvested in the transformation process.

VISNs must also examine the skills needed to take on an expanded role as facilitators, coaches, and guides in improving services and sharing best practices across facilities. VISNs are critical players in the feedback loop between service delivery and VHACO to identify ineffective processes, problems, and emerging issues that need to be raised to VHACO for help in clearing away barriers to effective operations. Similar to VHACO, VISNs must define the new skill set required by their staffs and establish these requirements in hiring, promotion, and performance evaluation as well as training and coaching staff to develop these competencies. Finally, the chief of VHA Care System (CVCS) should establish a required staffing ratio for the VISN office and reduce the staffing in VISNs that exceed this standard.

A new operating model also means that medical center directors must control the budget, staff, supplies, and infrastructure required to deliver needed health care. This model includes consolidation of budget lines and new authority and expanded authority to reallocate funds across the remaining budget categories. To manage the new VHA Care System and ensure that facility and network directors have the local control needed to make decisions about how to deliver services, fewer restrictions should be placed on the VHA budget. To start, specific-purpose funds must no longer be used to direct obligations at facilities. Congress should also work with the administration to reduce the number of budget lines and specific spending authorities back to a simpler system like that used in 1998. To support these changes and create transparency, medical centers should be accountable for their expenditure of funds by ensuring accurate, complete, and timely cost accounting. This last requirement, however, can only be met if it is supported by effective financial management data systems and fully trained staff and leadership who understand how to use such systems.

To support the leaders, program offices, and the field in this transformation, the CVCS must establish a transformation office that has appropriate expertise in business process reengineering and is fully funded to conduct this work. Existing offices with the requisite expertise, including the Office of Strategic Integration and the Veterans Engineering Resource Center (VERC), should be rolled into the transformation office. This office would oversee transformation and incubate new initiatives with the goal of incorporating them into regular work of other program offices once the new initiative is established. This mechanism, if used consistently, would prevent VHA from growing new offices as new priorities arise.

Finally, as part of cultural change within the leadership system, the CVCS, VISN directors, and program office leaders must promote open and productive dialogue among themselves about problems and solutions. To accomplish this goal, leaders must address both the culture within the leadership ranks, as well as establish systems and processes that support identification and discussion of problems. The CVCS must model this behavior by inviting input on problems and rewarding leaders when they bring issues forward, including rewarding them with access to expertise, staff, and money; removing barriers; and aligning other leaders in support of solutions.

In its work to oversee change in VHA, the transformation office will create an implementation plan for transformation, identifying key strategies and milestones. This plan will drive data collection, development of strategic goals and supporting objectives to encourage effective planning, accountability, and the ability to unearth critical gaps that need to be addressed. The transformation office will require each new initiative to establish a project plan and provide periodic reports that include all of the following components: tactic/action, initiative owner, cost (i.e., operational, equipment, contracts), number of FTEs, start and completion dates, outcome measures, strategic drivers, and milestone.⁴⁴⁷ The President's Management Agenda Scorecard will serve as the evaluation model. The Office of Management and Budget created this tool to evaluate new initiatives and track progress on outcomes over time with regular spotlight reports (red, yellow, green) to leadership.⁴⁴⁸

Implementation

Legislative Changes

- Simplify the VHA budget to include fewer accounts while at the same time requiring more transparent and detailed accounting of VHA expenditures.

VA Administrative Changes

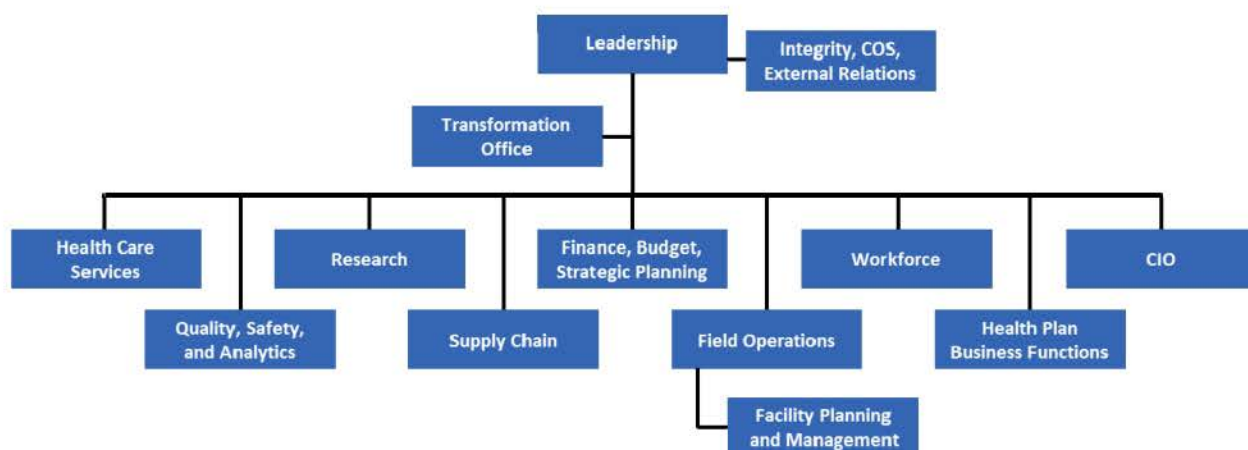
The following administrative changes are a priority during the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B. Responsibility for establishing a transformation plan with milestones, timelines, and evaluation of outcomes is assigned to the transformation office that the Commission recommends be established in VHA.

- Eliminate duplication within VHA and consolidate program offices to create a flat structure. Figure 9 is one model of an organizational chart for accomplishing this goal. This organizational chart shows how VHA can be streamlined to mirror the structure of large private-sector hospital systems. Figure 10 is the current VHA organizational chart, provided as a point of comparison and to emphasize the cumbersome nature of the current structure.

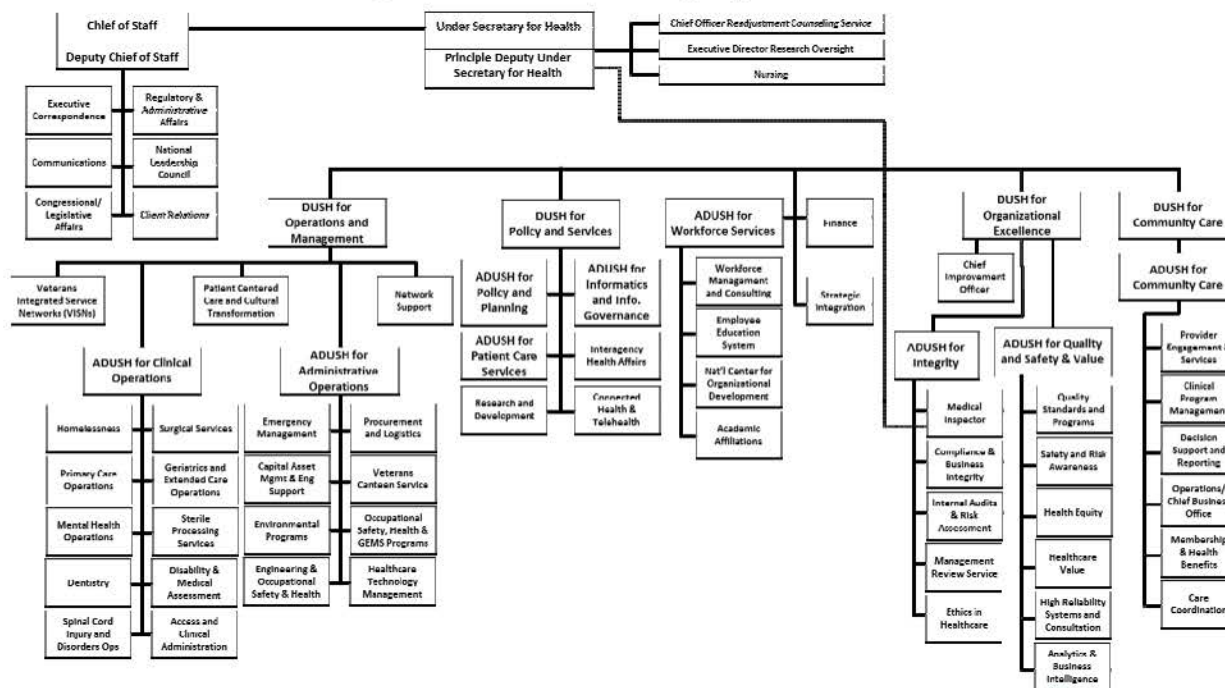
⁴⁴⁷ For example, see "VA Faith-based and Community Initiative President Management Agenda Scorecard," September 30, 2008,

⁴⁴⁸ "Office of Federal Financial Management President's Management Agenda," Office of Management and Budget, accessed June 15, 2016, https://www.whitehouse.gov/omb/financial_fia_pma/.

COMMISSION ON CARE FINAL REPORT

Figure 9. Proposed VHA Organizational Chart⁴⁴⁹

Note: This organizational chart is an example of how to align VHA functions to create a flatter organization, remove duplication, and streamline decision making as discussed throughout this section of the report. Of note, the placement of the Transformation Office, CIO, and supply chain in this diagram is consistent with recommendations made by the Commission elsewhere in this report. In this chart, COS is chief of staff.

Figure 10. Current VHA Organizational Chart⁴⁵⁰

⁴⁴⁹ Modified from Appendix C, Mike Mayo-Smith and Pat Vandenberg, *Task Force on Improving Effectiveness of VHA Governance: Report to the VHA Under Secretary for Health*, (Washington, DC, Veterans Health Administration, February 2015), 41.

⁴⁵⁰ Ibid.

- Eliminate the duplication of functions between VHA and VA by closing VHA offices as needed.
- Create innovative organizational structures that are aligned to patient's needs rather than professional silos, to support clinical care.
- Undertake a reduction-in-force in VHACO that facilitates layering and efficiency in communication and decision making.
- Establish a transformation office implementation plan to ensure effective and comprehensive implementation of the transformation across VHA. The transformation plan is to capture all of the transformation activities recommended in the Commission report, establish specific timelines and milestones for accomplishing each objective, and report on both progress and outcomes at least quarterly to VHA leadership and the governing board. Periodic evaluation of the effect of these change initiatives on internal and external stakeholders would also be appropriate.
- Clarify the roles and responsibilities of VISNs and facilities and implement a change strategy to orient staff and leaders to these new expectations. Establish effective leadership communication mechanisms to promote transparency, dialogue, and collaboration among VHACO offices and with the field.

Other Department and Agency Administrative Changes

- None required.

Recommendation #13: Streamline and focus organizational performance measurement in VHA using core metrics that are identical to those used in the private sector, and establish a personnel performance management system for health care leaders in VHA that is distinct from performance measurement, is based on the leadership competency model, assesses leadership ability, and measures the achievement of important organizational strategies.

Problem

To achieve the Commission's vision of quality, access, and choice for veterans, VHA must effectively measure outcomes and hold leaders accountable for improvement. VHA can measure itself against internal best practices, but veterans deserve care that uniformly meets or exceeds private-sector quality standards. A clear, concise, balanced measure set, identical to private-sector standards, will give leadership, staff, and administrators focus and direction for their work. VHA leaders are responsible for delivering these quality outcomes for veterans. They do so by exercising leadership skills and traits in their management and direction to staff. Short-term gains can be realized at the expense of staff morale and well-being, but the long-term health of the organization cannot. Therefore, organizations must be sure to assess leaders' performance not just on *what* they achieve but *how* they achieve it.

Background

One of the criteria for performance excellence in health care is the measurement, analysis, and improvement of organizational performance.⁴⁵¹ Performance measurement is used to track daily operations, overall organizational performance, and progress in achieving organizational objectives and action plans. Performance measurement is also used to benchmark organizational performance against internal and external standards.

Organizational performance measurement is not the same as workforce performance management.⁴⁵² Workforce performance management is intended to reinforce intelligent risk taking, help focus the workforce on the needs of patients and other customers, and support

The Commission Recommends That . . .

Organizational Performance Measurement

- VHA streamline organizational performance measures, emphasize strategic alignment and meaningful effect, and use benchmarked measures that allow a direct comparison to the private sector.
- The new Office for Organizational Excellence work with experts to reorganize its internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Workforce and Leadership Performance Management System

- VHA create a new performance management system appropriate for health care leaders, tied to health care leadership competencies, and benchmarked to the private sector.
- The CVCS and all secondary raters hold primary raters accountable for creating meaningful distinctions in performance among leaders.
- VHA recognize meaningful distinctions in performance with meaningful awards.

⁴⁵¹ Baldrige Performance Excellence Program, 2015-2016 *Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁵² Ibid., 20.

health care delivery and the achievement of action plans.⁴⁵³ Although there is a relationship between organizational performance measurement and workforce performance management, they are not synonymous processes.

Workforce performance management is made up of much more than just clinical outcome measures. As noted by the American College of Healthcare Executives (ACHE), performance evaluations of hospital CEOs must also evaluate leadership traits such as judgment, communication, and diplomacy.⁴⁵⁴ Furthermore, ACHE emphasizes the inclusion of individual professional objectives in performance plans, such as promoting ethical behavior, supporting diversity and inclusion within the organization, or fostering effective medical staff relationships.⁴⁵⁵ ACHE and other leading practitioners⁴⁵⁶ emphasize that performance management is not a plan or an event, but rather a continuous, ongoing process and conversation among the leaders and their reviewers. A workforce performance management system must also make meaningful distinctions among individuals⁴⁵⁷ and promote high performance through rewards, recognition, and incentive practices.⁴⁵⁸ Ideally, when coupled with a leadership competency model and development program, workforce performance management should also help to identify high-performing potential leaders and provide guidance to the workforce on how to move up in the leadership ranks.⁴⁵⁹ As deployed in FY 2015 and evaluated by the *Independent Assessment Report*, VHA's performance management system failed to effectively achieve any of these objectives.⁴⁶⁰

Analysis

One of the findings in the *Independent Assessment Report* was that “hundreds of operational performance measures overwhelm leaders and this, combined with limited transparency and inconsistent data availability, makes it difficult to focus on what is most important.” More than 300 measures spanned everything from critical clinical metrics to political priorities introduced to address the most recent crisis. VHA reports that it was tracking approximately 500 measures,

⁴⁵³ Ibid.

⁴⁵⁴ “Policy Statement: Evaluating the Performance of Hospital or Health System CEO,” November 2013 (revised), American College of Healthcare Executives, accessed February 18, 2016, <https://www.ache.org/policy/ceo-perf.cfm>.

⁴⁵⁵ Ibid.

⁴⁵⁶ Ibid. NeuroLeadership Institute’s “Reengineering Performance Management: How Companies are Evolving Beyond Ratings” webinar, scheduled on January 14, 12-1.

⁴⁵⁷ “Implementing FCAT-M Performance Management Competencies: Differentiating Performance,” Office of Personnel Management, Performance Management: Performance Management Cycle, accessed June 10, 2016, <https://www.opm.gov/policy-data-oversight/performance-management/performance-management-cycle/developing/differentiating-performance/>.

⁴⁵⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization’s Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁵⁹ Office of Personnel Management. Proficiency Levels for Leadership Competencies. <https://www.opm.gov/policy-data-oversight/proficiencylevelsforleadershipcompetencies/>. “Joint Medical Executive Skills Institute,” Health.mil: The official website of the Military Health System and the Defense Health Agency, accessed June 13, 2016, <https://www.jmesa.army.mil/documents.asp>, National Center for Healthcare Leadership. NCHL Healthcare Leadership Competency Model. <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁶⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78-79, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

COMMISSION ON CARE FINAL REPORT

including 156 related to access, 29 measuring employee engagement, 18 on high-performing networks, 250 best practice measures, and seven related to trust.⁴⁶¹

Distinct from performance measurement, the performance management process⁴⁶² is a cycle that begins with clear input from top leadership on the priorities of the organization, followed by clear targets, performance tracking, reviews, and rewards. The *Independent Assessment Report* noted that, “Individual performance management processes are hindered by targets inconsistent with the VHA mission, delayed implementation, lack of meaningful performance dialogue, and limited rewards.”⁴⁶³ Many of the same system flaws that impede effective organizational performance also impede individual success. Performance plans are released late in the performance cycle,⁴⁶⁴ metrics are hard to track in real time and lack the detail required for individual performance assessment,⁴⁶⁵ and few plans are written to support shared accountability and team-based solutions. In addition, participants observed that the current senior executive performance agreements and rating process (a) do not result in meaningful distinctions in performance between individuals, (b) do not drive meaningful conversations about individual performance, (c) and do not consistently focus on key health care metrics of quality, safety, patient experience, operational efficiency, finance, and human resources.⁴⁶⁶ The *Independent Assessment Report* notes that the rewards currently offered to employees do not motivate them to work toward exceptional performance.⁴⁶⁷

Information provided to the Commission indicates that VHA has taken action to address some of these findings. First, the USH has reestablished a performance accountability workgroup (absent for a number of years) comprising leaders from the field and VHACO to provide oversight and direction to the performance measurement process.⁴⁶⁸ The workgroup has been charged with aligning metrics to each level of VHA, dramatically simplifying metrics, and increasing the capacity of the organization to focus on measures that truly matter.⁴⁶⁹ The group has created an aspirational vision of a performance measurement system that describes cascading accountability from the top of the organization with health system outcomes (reported annually) through strategic measures (reported quarterly), to tactical measures (reported monthly) to transactional measures (reported in real time).⁴⁷⁰ It is critical that these aspirations become policy.

⁴⁶¹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁶² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 78, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁴⁶³ Ibid., 82.

⁴⁶⁴ Ibid., 82.

⁴⁶⁵ Ibid., 84.

⁴⁶⁶ Ibid., 84.

⁴⁶⁷ Ibid., 87.

⁴⁶⁸ David Shulkin, *Charter of the Performance Accountability Workgroup*, (Washington, DC, Veterans Health Administration, September 22, 2015).

⁴⁶⁹ Carolyn Clancy and Joe Francis, Veterans Health Administration, meeting with Commission on Care staff, December 2015.

⁴⁷⁰ Ibid.

Starting in the 1990s, VHA has used performance measurement, benchmarking, and reporting internally to motivate higher clinical quality performance by individuals and teams.⁴⁷¹ As a large, national health care system, internal benchmarking can be a valid method to drive change, yet both internal and external audiences may ask how well VHA performance compares to that of private-sector providers. VHA currently posts some patient quality, safety, and outcome measures on both its website and on the Department of Health and Human Services (HHS) Hospital Compare website.⁴⁷² These measures allow patients to evaluate the quality of care they receive from VA and make informed health care decisions. They include measures of timely and effective health care; measures of readmissions; complications of death, surgical complication measures and health-care related infection measures; survey data of patient experiences; and other measures required of hospitals participating in Medicare.⁴⁷³ Former USH Kizer believes this reporting is insufficient, noting

*the VA health care system has become increasingly insular and inward-looking. It now has little engagement with private-sector health care, and too often it has declined to make its performance data public. For example, it contributes only a small proportion of its data to Hospital Compare and has declined to participate in other public performance reporting forums such as the Leapfrog Group's efforts to assess patient safety.*⁴⁷⁴

The Commission has reviewed VHA's principal measurement approach, Strategic Analytics for Improvement and Learning Value Model (SAIL) and has determined that although it is modelled on private-sector approaches to measurement and rating, measures are not exactly the same as those reported in the private sector and consequently impede direct benchmark comparisons of VHA to the private sector. Updating these measures so they are consistent with the private sector will be especially important as integrated delivery networks are established and more care is received in the community, as they will allow for making objective comparisons.

Measurement, analysis, and improvement of organizational performance work together as a key system.⁴⁷⁵ The USH has signed a new organizational chart for VHA that acknowledges the interconnection of these elements by establishing an office for organizational excellence that encompasses all of these functions.⁴⁷⁶ To be effective, not only must all of the various units within this office work together but also they must work with personnel in the field to coach and develop their ability to effectively apply performance measurement and improve organizational performance.

⁴⁷¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation?" Ashish K. Jha, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, September 2006, accessed April 21, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31/what-can-the-rest-of-the-health-care-system-learn-from-the-vas-quality-and-safety-transformation>.

⁴⁷² "Quality of Care: How Does Your Medical Center Perform?" Medical Center Performance Search (MCPS), U.S. Department of Veterans Affairs, accessed May 16, 2016, <http://www.va.gov/qualityofcare/apps/mcps-app.asp>.

⁴⁷³ Title XVIII of the Social Security Act 42 U.S.C. § 1395 et seq.

⁴⁷⁴ Kenneth Kizer and Ashish Jha, *Restoring Trust in VA Health Care*, N Engl J Med 2014; 371:295-297, July 24, 2014

⁴⁷⁵ Baldrige Performance Excellence Program, 2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care), Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 16.

⁴⁷⁶ See the proposed organizational chart at end of Recommendation #12.

COMMISSION ON CARE FINAL REPORT

These improvements in performance measurement do not appear to be mirrored on the performance management side of the equation. The draft FY 2016 performance plan template for network directors and medical center directors,⁴⁷⁷ although more streamlined than in previous years, continues to reflect confusion of performance measurement and performance management. It also continues to distribute all of the organization's key (and not so key) priorities under OPM executive core qualifications of leading change, leading people, business acumen, building coalitions, and results driven. The new, streamlined performance measures described above could be considered results-driven; however, the rest of the plan continues to be a confusing presentation of instructions to field leaders, restatements of policy, and performance objectives for action plans. Only the last category is appropriate for workforce performance management.⁴⁷⁸ The Corporate Senior Executive Management Office has implemented a new online performance management data tool that allows for tracking and assessment of the performance management process for senior executive service and equivalent leaders in VA.⁴⁷⁹

To improve performance measurement and organizational performance, the *Independent Assessment Report* recommends that VHA focus and simplify organizational performance measurement to clarify accountability, actively support the mission, and promote continuous improvement. Specifically, VHA must create a simplified, focused, balanced scorecard that reduces the total number of metrics to about 20; establish metrics that support cross-functional collaboration; cascade metrics down the organizational hierarchy; and make data tracking transparent, timely, broadly available, credible, reliable, and meaningful down to the lowest level of the organization. Furthermore, leaders should support continuous improvement, problem-solving, and the exchange of best practices across the organization rather than focusing on only correcting poor performance.⁴⁸⁰ The Commission broadly agrees with this approach to performance measurement. In addition, the Commission emphasizes that VHA customers and stakeholders require public reporting of clinical quality measures that are the same as, and therefore directly comparable to, measures used by the private sector. Although VHA may require an enhanced set of measures that reflects services not broadly deployed in the private sector, or for which measures do not yet exist, a minimum set that are the same as private-sector measures must be used by VHA. As VHA expands integration of care with the community, the use of the same measures as the private sector will be important so that direct comparisons can be made of care delivered inside VHA and that delivered under contract or partnership agreement by the VHA community care network.

VHA also requires a cohesive, integrated personnel performance management system that is specific to the knowledge, skills, and abilities required of health care leaders; includes

⁴⁷⁷ Veterans Health Administration, *Draft Fiscal Year 2016 Performance Plan Template*, Network Directors and Medical Center Director, November 20, 2015.

⁴⁷⁸ Baldrige Performance Excellence Program, *2015-2016 Baldrige Excellence Framework: A Systems Approach to Improving Your Organization's Performance (Health Care)*, Gaithersburg, MD: U.S. Department of Commerce, National Institute of Standards and Technology (2015), 20.

⁴⁷⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁴⁸⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 81, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

accountability to key organizational outcomes; but also assesses organizational and professional objectives. A new personnel performance management system must be free of OPM requirements for executive core qualification and certification process and instead be benchmarked to the private sector⁴⁸¹ and consistent with the new leadership competency model. Congress required DoD to establish independent competency standards for the Commanders of Military Treatment Facilities (MTFs) and should consider doing the same for VHA.⁴⁸² This new performance management model must be based on both evaluation of leadership competencies and demonstrated success in delivering on strategic priorities. To break with current perceptions of the rating scales, it would be helpful to establish a new rating scale for the performance management system. Once the new system is developed, VHA must conduct training to describe the system, rating process, and expectations for both participants and raters.

A performance management system must also address the responsibilities of the rater. This includes clearly establishing written performance requirements for subordinates that are both timely (i.e., prior to the start of the rating period) and meaningful. Raters must be required to provide continuous feedback and assessment throughout the year to recognize and reward progress and outstanding achievements as well as to coach and trouble shoot when needed. The CVCS must establish this expectation by clearly communicating what is required of raters, and most importantly, by modeling the behavior. Finally, raters must provide meaningful ratings that distinguish achievement based on objective performance and demonstrated leadership skills. For instance, the Cleveland Clinic has moved to a system of forced rankings for which the top 10 percent of performers are celebrated and the bottom 10 percent are given intensive coaching or, if justified, sanctioned.⁴⁸³ To accomplish the last point, raters themselves must be given feedback and oversight to understand how their approach to rating compares to other leaders in the organization. If raters' assessments are not consistent with rating standards, their supervisor must bring this issue to their attention and include it in the performance assessment they receive.

The newly established performance management data tool can be used to support the performance management process. The submission of written performance plans (or failure to do so) can be tracked and reported; and the quality of those plans can be audited to provide feedback to raters. Final ratings and a comparison of raters can be conducted and provided to all of the executive raters in the organization. Finally, such a tool can also be used to identify and track high performers who deserve further investment and development as leaders from VHA.

⁴⁸¹ The American College of Healthcare Executives, *2016 Competencies Assessment Tool*, accessed May 16, 2016, https://www.ache.org/pdf/nonsecure/careers/competencies_booklet.pdf. "NCHL Health Leadership Competency Model™," National Center for Healthcare Leadership, accessed May 16, 2016 <http://www.nchl.org/static.asp?path=2852,3238>.

⁴⁸² Department of Defense Appropriations Act of 1999, Pub. L. No 105-262, Section 8052 (1998): "None of the funds appropriated in this Act may be used to fill the commander's position at any military medical facility with a health care professional unless the prospective candidate can demonstrate professional administrative skills."

⁴⁸³ Delos M. (Toby) Cosgrove, MD, CEO, Cleveland Clinic, statement during Commission on Care public meeting, March 22, 2016.

COMMISSION ON CARE FINAL REPORT

Implementation***Legislative Change***

- Obtain legislative relief from the requirement to use the OPM executive core qualifications system of competencies and ratings and tied to new Title 38 pay authority for health care leaders (see Recommendation #15).

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Establish a workgroup and engage outside experts to create a new performance management system for VHA leaders that is appropriate for health care executives.
- Establish standards and processes to hold raters accountable for creating meaningful distinctions in performance between subordinate leaders.
- The new Office for Organizational Excellence should work with experts to reorganize their internal structure to align business functions with field needs and consolidate and eliminate redundant or low-priority activities.

Other Department and Agency Administrative Changes

- None required.

Diversity and Cultural Competence

Recommendation #14: Foster cultural and military competence among all VHA Care System leadership, providers, and staff to embrace diversity, promote cultural sensitivity, and improve veteran health outcomes.

Problem

The VHA Care System must implement a systemic approach to developing the cultural and military competence of its leadership, staff, and providers, as well as measure the effects of these efforts on improving health outcomes for vulnerable veterans. Although VHA has made some strides in specific program areas, cultural competency is an essential part of providing effective care to veterans, and must become a strategic priority throughout the organization, because of the unique needs military service, and especially participation in combat operations, may cause.

The Commission Recommends That . . .

- VHA implement a systemic approach to establishing cultural and military competence across VHA and its community providers, and provide the resources required to fully integrate the related strategy into veteran's care delivery.
- Cultural and military competency training be required on a regular basis for VHA Care System leadership, staff, and providers.
- Cultural and military competency be criteria for allowing community providers to participate in the VHA Care System.

Background

Cultural competence is the ability of health care organizations and their providers to understand and respond effectively to the cultural, language, and in VA's case, military service experience brought by the patient to the health care encounter. It has been endorsed as a viable skill set to reduce, if not eliminate, the rate at which health care disparities occur. VHA has recognized the problem of health disparities among its patient population and has taken steps to address it by tasking certain internal offices with building cultural and military competence throughout the organization. For example, VHA established the Office of Health Equity (OHE) and charged it with championing the efforts to identify, understand, and address health care disparities among veterans.

Analysis

There are seven essential strategies for promoting and sustaining organizational and systemic cultural competence. These strategies include the following:⁴⁸⁴

- Provide executive-level support and accountability.
- Foster patient, community, and stakeholder participation and partnerships.
- Conduct organizational cultural competence assessments.
- Develop incremental and realistic cultural competence action plans.

⁴⁸⁴ Miriam E. Delphin-Rittmon et al., "Seven Essential Strategies for Promoting and Sustaining Systemic Cultural Competence," *Psychiatric Quarterly*, 84, (2013), 53-64.

COMMISSION ON CARE FINAL REPORT

- Ensure linguistic competence.
- Diversify, develop, and retain a culturally competent workforce.
- Develop an agency strategy for managing staff and patient grievances.

VA has taken some steps to address cultural and military competence strategies, but these programs are not sufficient to address the breadth and depth of the problem. These strategies will not take hold and become fully ingrained in VHA's culture unless VHA leadership makes them a key priority and commits the resources and on-going, comprehensive training required to build cultural competencies across the entire VHA workforce.

Military Competency

In addition to addressing the needs of minority veterans and vulnerable veterans populations, VA must address military-specific needs and ensure that all providers in the VHA Care System have sufficient military competency (i.e., knowledge of specific issues and health care needs of those who served in the military). VHA's Office of Academic Affiliations developed a *Clinician Pocket Card* for providers that includes questions for clinicians to ask veterans about their military health history.⁴⁸⁵ The *Pocket Card* and similar resources should be given to all VHA and community providers to leverage during veteran patient medical assessments and appointments. In addition, VA's Office of Public Health (OPH) provides information on VA health care programs for veterans who were exposed to environmental and occupational hazards during military service, such as Agent Orange, chemicals leading to Gulf War veterans' illnesses, and Camp Lejeune water contamination.⁴⁸⁶ This military exposure information should be leveraged in VA's cultural competency strategy.

Health care disparities often result from patients' lack of trust in their health care provider; therefore, enhancing the patient-provider relationship is paramount in overcoming these disparities. Stereotypical thinking on the part of providers about certain patient groups, including veterans, may unwittingly influence their prognosis.⁴⁸⁷ Specific reasons for the increase of health care disparities in the military population include the following:

- the cultural norms of the military are such that to admit or display any signs of perceived weakness, especially related to mental health issues, discourages military personnel and veterans from seeking medical care and treatment
- changes in the demographical makeup of the civilian population result in similar changes to the military population
- a small but gradual increase in the number of foreign born personnel who have joined the ranks of the military

⁴⁸⁵ Department of Veterans Affairs, Office of Academic Affiliations, *Military Health History: Pocket Card for Health Professions Trainees and Clinicians*, accessed June 12, 2016, <http://www.va.gov/oaa/archive/Military-Health-History-Card-for-print.pdf>.

⁴⁸⁶ "Public Health: Military Exposures," U.S. Department of Veterans Affairs Intranet, accessed June 12, 2016, <http://vaww.publichealth.va.gov/exposures/index.asp>

⁴⁸⁷ G.L.A. Harris, "Reducing Healthcare Disparities in the Military Through Cultural Competence," JHHSA (2011), 148.

- a disengaged provider culture that may have become more immersed in the medical culture than the military culture

VA must make cultural and military competence a strategic priority, provide the resources needed to execute the strategy, and hold leadership and providers, both within VHA and community partners, accountable for strategy implementation and integration into VA's culture.

Women

Women are the fastest growing group within the veteran population.⁴⁸⁸ As of 2011, approximately 1.8 million (8 percent) of the 22.2 million veterans were women. Data indicate that by 2020 women veterans will comprise nearly 11 percent of the total veteran population. As the number of women veterans increases, VHA continues to prepare for an increasing demand for women veterans' health care needs.⁴⁸⁹ To address the health disparities affecting women veterans, VHA must provide high-quality, equitable care on par with that of men, deliver that care in a safe and healing environment, provide seamless coordination of services, and actively recognize women as veterans.⁴⁹⁰

In the past, VHA found gaps in its ability to provide comprehensive primary care for women veterans because many primary care providers had little or no exposure to women patients and women were often referred outside of primary care for gender-specific care. To close these gaps, VHA has implemented women's health comprehensive primary care clinic models with the goal of providing complete primary care from one designated women's health provider (DWHP) at one site. An analysis of FY 2012 data revealed that women assigned to DWHPs had more positive overall experiences with care and were more satisfied on six composite scores including access, communication, shared decision making, self-management support, comprehensiveness, and office staff.⁴⁹¹ VA has substantially reduced gender gaps in care,⁴⁹² but women veterans still encounter challenges when accessing care. VHA leadership must support the future planning of women's services and programming so that women veterans receive the highest quality health.⁴⁹³

LGBT Equity

In its systemwide implementation of cultural competency, VHA should leverage best practices from an area in which the agency is already an equity leader: treatment of LGBT patients. Every year since 2007, the Human Rights Campaign has published a Health Equality Index (HEI) report that aims to measure the quality of health care for LGBT patients based on core criteria

⁴⁸⁸ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

⁴⁸⁹ U.S. Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care*, April 2015, accessed June 12, 2016, http://www.womenshealth.va.gov/WOMENSHEALTH/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf.

⁴⁹⁰ Patricia M. Hayes, Chief Consultant Women's Health Services, VHA Office of Patient Services, briefing to the Commission on Care, October 19, 2015.

⁴⁹¹ Ibid.

⁴⁹² Ibid.

⁴⁹³ "Women Veterans Health Care," Department of Veterans Affairs, accessed June 12, 2016, <http://www.womenshealth.va.gov/>.

COMMISSION ON CARE FINAL REPORT

that require health care systems to couple strong policies with appropriate training.⁴⁹⁴ In 2016, VAMCs made up 20 percent of all HEI participants. Among participating VAMCs, 84 percent were designated with *Leader* status.⁴⁹⁵ VHA hospitals publicize that discrimination against LGBT patients and employees is prohibited. Senior managers are registered for HEI training. And equal visitation rights are granted to families and friends of LGBT patients. VHA hospitals play a critical role in promoting patient care equality in states where VHA is the only Equality Leader.⁴⁹⁶ VHA should create strong policies and mandatory training, like that used to promote health equity for LGBT patients, to address equity issues for racial and ethnic minorities and women.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- VHA Care System providers should be required to ask patients about their military health history and incorporate veterans' responses into patients' treatment plans.
- VHA leadership should support the future planning of women's services and programming so that women veterans receive the highest quality health care.
- VHA should leverage the best practices developed in support of LGBT equity and implement them across VHA.
- VHA Care System providers should be required to attend comprehensive, on-going cultural and military competency training.

Other Department and Agency Administrative Changes

- None required.

⁴⁹⁴ "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-va-leading-way-lgbt-patient-care>.

⁴⁹⁵ "Office of Health Equity: Healthcare Equality Index," U.S. Department of Veterans Affairs, accessed June 15, 2016, http://www.va.gov/HEALTHYEQUITY/Healthcare_Equality_Index.asp

⁴⁹⁶ "How the VA is leading the way on LGBT patient care," Andrew Park, The Week, February 25, 2014, accessed June 12, 2016, <http://theweek.com/articles/450361/how-va-leading-way-lgbt-patient-care>.

Workforce

Recommendation #15: Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.

Problem

VHA has staffing shortages and vacancies at every level of the organization and across numerous critical positions, including facility leadership, clinical staff, supply chain personnel, and customer service staff. VHA lacks competitive pay, must use inflexible hiring processes, and continues to use a talent management approach from the last century. A confusing mix of personnel authorities and position standards make staffing and management a struggle for both supervisors and human resources personnel. Title 5 was not created with a modern health care delivery system in mind and falls short of offering what is needed to create a high-performing health care system.

Background

During the 1990s, Congress passed the Government Performance and Results Act⁴⁹⁷ to correct shortcomings in the way government was managed and assessed in an effort to bring modern business management practices into the federal government. The law was updated in 2011,⁴⁹⁸ yet one essential

The Commission Recommends That . . .

- Congress create a new alternative personnel system that applies to all VHA employees and falls under Title 38 authority. The system must simplify human capital management in VHA; increase fairness for employees; and improve flexibility to respond to market conditions relating to compensation, benefits, and recruitment.
- VHA write and implement regulations for the new alternative personnel system, in collaboration with union partners, employees, and managers, that does all of the following:
 - Meets benchmark standards for human capital management in the health care sector and is easy for HR professionals and managers to administer.
 - Promotes veteran preferences and hiring.
 - Embodies merit system principles (merit-based, nonpartisan, nondiscrimination, due process) through simplified, sensible processes that work for managers and employees.
 - Creates one human capital management process for all employees in VHA for time and leave, compensation, advancement, performance evaluation, and disciplinary standards/processes.
 - Provides due process and appeals standards to adverse personnel actions.
 - Allows for pay advancement based on professional expertise, training, and demonstrated performance (not time-in-grade).
 - Promotes flexibility in organizational structure to allow positions and staff to grow as the needs of the organization change and the success of each individual merits.
 - Establishes simplified job documentation that is consistent across job categories and describes a clear path for staff professional development and career trajectories for advancement.
 - Eliminates most distinctions (except for benefits) between part-time and full-time employees.
 - Grandfathers current employees with respect to pay and benefits.
- VHA ensure all positions, to include human resources management staff, are adequately trained to fulfill duties.

⁴⁹⁷ Government Performance and Results Act of 1993, Pub. L. No. 103-62, 107 Stat. 285 (1993).

⁴⁹⁸ GPRM Modernization Act of 2010, Pub. L. No. 111-352, 124 Stat. 3866 (2011).

COMMISSION ON CARE FINAL REPORT

component of modernizing the management of federal programs is still missing: reform of human capital management.⁴⁹⁹

The Civil Service Act was initially passed in 1883 and revised in 1978.⁵⁰⁰ The *general schedule*, which governs the pay and job classification process, was codified by regulation in 1949. The U.S. workforce, including the federal workforce, has changed dramatically since these laws and regulations were implemented. As noted in a recent report from the Partnership for Public Service, “the personnel system, designed more than 60 years ago, now governs more than 2 million workers and is a relic of a bygone era, reflecting a time when most federal jobs were clerical and required few specialized skills.”⁵⁰¹ As of 2013, nearly two-thirds of federal employees work in professional or administrative positions focused on knowledge-based work, with the Department of Veterans Affairs accounting for the largest percentage of such workers.⁵⁰²

The Partnership for Public Service calls for broad reform of the civil service system, noting that the

*the federal workforce has become an island disconnected from the larger talent market for knowledge-based professional and administrative occupations that are mission critical. . . . Federal employee pay . . . is not tied to the broader labor market, making it harder to compete with the private sector for talent. That disconnect is exacerbated by a job classification system that describes a workplace from the last century.*⁵⁰³

This system lacks mechanisms for rewarding top performers, demoting or firing poor performers, and holding managers accountable.⁵⁰⁴ The unnecessarily complex hiring system is difficult for applicants to navigate and makes it challenging for hiring managers to identify the most qualified candidates, hindering the ability to bring in experienced candidates from the private sector.⁵⁰⁵

*The civil service system has become a maze of rules and procedures that are not perceived as rational by the people who serve in government or by the general public. . . . Rigid policies . . . are now a burden on a government that needs to encourage flexibility and innovation to meet rapidly changing and difficult challenges.*⁵⁰⁶

⁴⁹⁹ U.S. General Accountability Office, Office of the Comptroller General, *Human Capital – A Self-Assessment Checklist for Agency Leaders*, accessed April 11, 2016, <http://www.gao.gov/assets/80/76520.pdf>. U.S. General Accountability Office, *Transforming the Civil Service: Building the Workforce of the Future – Results of a GAO Sponsored Symposium*, accessed April 11, 2016, <http://www.gao.gov/assets/200/197256.pdf>.

⁵⁰⁰ The Pendleton Civil Service Reform Act of 1883, Pub. L. No. 16, 22 Stat. 403 (1883).

⁵⁰¹ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰² Ibid. The Department of Defense in total has more knowledge workers but the numbers for each service are reported independently and are below the total for the VA workforce.

⁵⁰³ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 11, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵⁰⁴ Ibid.

⁵⁰⁵ Ibid.

⁵⁰⁶ Ibid.

The General Accounting Office (GAO) also continues to point to human capital management as a high-risk area across government.⁵⁰⁷ DoD has proposed walking away from the Title 5 civil service system to support modernization of human capital management,⁵⁰⁸ President Barack Obama has repeatedly called for a commission to overhaul and modernize the civil service,⁵⁰⁹ and Congress is considering whether the time is right for civil service reform.⁵¹⁰

VHA currently uses three different personnel systems: Title 5 (the civil service/general schedule system) for senior executive service (SES) and other, mostly nonclinical, employees; Title 38 for physicians, dentists, and other specified health care professionals;⁵⁰⁹ and Title 38 Hybrid for allied health professionals such as pharmacists and licensed physical therapists.⁵¹⁰ Each system has its own set of requirements, procedures, and rules for the employees under its respective authority.⁵¹³ Currently, about two-thirds of VHA employees serve in the Title 38 Hybrid occupations.⁵¹⁴

VHA is not alone in having an excepted service system. More than a dozen agencies have special legislative authority to create a personnel system to fit their particular needs, including the Federal Bureau of Investigation, National Institutes of Health, National Security Agency, U.S. Public Health Service, Defense Intelligence Agency, U.S. Nuclear Regulatory Commission, and National Aeronautics and Space Administration.⁵¹¹ In an acknowledgement of the failure of the general schedule process to meet the needs of certain professions, OPM has also instituted governmentwide direct hiring authority for difficult-to-recruit positions, including medical officer, nurse, pharmacist, radiologic technician, and information technologist—all positions critically important to VHA's mission success.

Modernizing human capital management is a global imperative for the private sector as well, with 92 percent of participants in one assessment of 7,000 businesses noting that a new approach to human resources is a critical organizational priority in 2016.⁵¹² According to a report from Deloitte, which examined broad human resource (HR) trends, "HR is redesigning almost everything it does—from recruiting to performance management to onboarding to reward systems" to learning and development.⁵¹³ Younger workers are driving many of these

⁵⁰⁷ U.S. GAO, *Federal Workforce—Human Capital Management Challenges and the Path to Reform, Testimony Before the Subcommittee on Federal Workforce U.S. Postal Service and the Census, Committee on Oversight and Government Reform, House of Representatives, Statement of Robert Goldenkoff*, GAO-14-723T, July 15, 2014, Washington, DC, 2014, accessed June 12, 2016, <http://www.gao.gov/assets/670/664772.pdf>.

⁵⁰⁸ "Draft Proposal Calls for Major Revamp of DoD Civilian Personnel System," Jared Serbu, Federal News Radio, accessed April 8, 2016, <http://federalnewsradio.com/defense/2015/09/draft-proposal-calls-major-revamp-dod-civilian-personnel-system/>.

⁵⁰⁹ "Obama's Budget Touts Progress Within Federal Workforce, but Offers It Nothing New," Eric Katz, Government Executive, accessed April 8, 2016, <http://www.govexec.com/management/2016/02/obamas-budget-touts-progress-within-federal-workforce-offers-it-nothing-new/125815/>. The Office of Management and Budget, *Fiscal Year 2016 Budget of the U.S. Government*, accessed May 13, 2016, <https://www.whitehouse.gov/sites/default/files/omb/budget/fy2016/assets/budget.pdf>.

⁵⁰⁹ "Brace Yourselves: Congress Preps Civil Service Reform," Andy Medici, Federal Times, accessed April 8, 2016, <http://www.federaltimes.com/story/government/management/oversight/2015/01/19/congress-civil-service-reform/21458717/>.

⁵¹⁰ Ibid.

⁵¹¹ See, e.g., 38 U.S.C. § 7401(1).

⁵¹² See, e.g., 38 U.S.C. § 7401(3).

⁵¹³ Joleen Clark, Jack Hetrick, and Donna Schroeder, "Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers," Alternative Personnel System (2014).

COMMISSION ON CARE FINAL REPORT

changes with expectations for meaningful work, learning opportunities, and career progression.⁵¹⁴ These workers have been choosing the federal government in diminishing numbers, with only 6 percent of federal employees currently younger than 30 years of age (compared to 23 percent of the civilian workforce).⁵¹⁵ In VHA, millennials (those 34 and younger) make up only 15 percent of the workforce, but are disproportionately over-represented among staff that quit VHA, at 20 percent.⁵¹⁶

As of January 2016, VHA had a vacancy rate of 16 percent for all positions, despite filling more than 40,000 positions in FY 2015.⁵¹⁷ VHA faces the additional challenge that 40 percent of its overall workforce is eligible for retirement in the next few years.⁵¹⁸ This problem occurs in the face of acknowledged national shortages of physicians⁵¹⁹ and geographic misalignment of the current health care workforce that leaves many localities short of needed providers.⁵²⁰ Taken together, this information makes clear that excellence in human capital management continues to be a business imperative for VHA.

Analysis

The human resource function within VHA needs a fundamental overhaul to increase responsiveness, efficiency, and customer service, as well as to align its orientation to the business needs of VHA.⁵²¹ Medical center directors do not receive the support they need from HR to accomplish hiring, disciplining, and planning for succession of employees.⁵²² During exit interviews, staff members who leave VHA cite barriers to career growth, insufficient professional development, a lack of promotions, and poor on-boarding and training as reasons for departing.⁵²³ In a recent national survey of VA employees, improving end-to-end hiring, recognizing stellar job performance, and providing professional development and career

⁵¹⁴ U.S. GAO, *The Excepted Service: A Research Profile*, GAO/GGD-97-92, accessed April 12, 2016, <http://www.gao.gov/assets/80/79968.pdf>.

⁵¹⁵ Partnership for Public Service, *Building the Enterprise: A New Civil Service Framework*, accessed April 12, 2016, <https://ourpublicservice.org/publications/download.php?id=18>.

⁵¹⁶ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

⁵¹⁷ “VA Struggles to Fill Medical Center Positions in Arizona, Across Nation,” Danika Worthington, Arizona Daily Sun, accessed April 5, 2016, http://azdailysun.com/news/local/va-struggles-to-fill-medical-center-positions-in-arizona-across/article_a14e6937-ecc1-5415-9391-7a6d759e5025.html.

⁵¹⁸ Joleen Clark, Jack Hetrick, and Donna Schroeder, *Leading Access Scheduling Initiative – People: Assessment of Hiring Barriers, Alternative Personnel System* (2014).

⁵¹⁹ IHS Inc., *The Complexities of Physician Supply and Demand: Projections from 2013-2025*, accessed April 12, 2016, <https://www.aamc.org/download/426242/data/ihsreportdownload.pdf>.

⁵²⁰ “Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations,” U.S. Department of Health and Human Services, Health Resources and Services Administration, accessed April 12, 2016, <http://www.hrsa.gov/shortage/>.

⁵²¹ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, x, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²² *Ibid.*, vii.

⁵²³ Veterans Health Administration Workforce Management & Consulting Office, Healthcare Talent Management, *VHA Workforce Planning Report 2015*, 9 and 13, accessed June 12, 2016, http://www.vacareers.va.gov/assets/common/print/2015_VHA_Workforce_Succession_Strategic_Plan.pdf.

planning ranked, numbers one, six, and nine respectively as top priorities for improving the employee experience at VA.⁵²⁴

The Civil Service System Does Not Support a High-Performing Health System.

Recruitment in VHA operates in an incredibly complex environment. Federal rules and regulations make HR more challenging than it is in the private sector.⁵²⁵ For example, interviews in 2014 with more than 500 VHA hiring managers and HR staff members pointed to the top problems with Title 5 recruitments as OPM classification standards, grading of position descriptions, position characterization, and the ranking and rating process.⁵²⁶ The group specifically noted that there are many staff positions required in a health care delivery system that do not translate into a general schedule occupational series; therefore, when the positions are graded, the grade and salary is too low to compete with the private sector. Examples of such positions are custodial workers (hospital employees need to apply antiseptic cleaning techniques, but general custodians do not) and general facilities and equipment maintenance (hospital employees need to understand the maintenance of such items as specialized medical equipment, positive pressure rooms, and sterile plumbing systems that are not requirements for general plant maintenance at an office building).⁵²⁷ In another example, VHA managers noted that the OPM classification standard for supply chain positions rendered VHA unable to compete for local talent because the assigned grade was too low.⁵²⁸

The general schedule system also has been identified as a barrier to career advancement.⁵²⁹ Clerical staff members in particular often cannot advance in pay and responsibility without leaving their positions and moving into a different job series.⁵³⁰ Similarly, frontline customer service staff under the general schedule cannot receive advanced steps within the grade for better performance or completing job-related certifications or degrees, unlike nurses and allied health professionals who can receive advances in pay for these accomplishments.⁵³¹

The hiring process in VHA is acknowledged to take too long.⁵³² “HR is expected to fill a position within 60 calendar days . . . but process requirements, even if perfectly executed, take about 49

⁵²⁴ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵²⁵ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵²⁶ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People. Powerpoint of findings, July 29, 2014.

⁵²⁷ Veterans Health Administration, “Leading Access Scheduling Initiative – People, Assessment of Hiring Barriers,” VHA Classification Workgroup, 2014.

⁵²⁸ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, xiii, accessed December 28, 2015, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

⁵²⁹ Ibid.

⁵³⁰ “Classification and Qualification: Classifying General Schedule Positions,” U.S. Office of Personnel Management, accessed November 24, 2015, <https://www.opm.gov/policy-data-oversight/classification-qualifications/classifying-general-schedule-positions/>.

⁵³¹ Pay Administration, VA Directive 5007 (2002). Staffing, VA Directive 5005 (2002).

⁵³² McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

COMMISSION ON CARE FINAL REPORT

to 62 days.” Hiring timelines can span 4-8 months compared to private-sector hiring that takes between 0.5 and 2 months.⁵³³

This finding was echoed in a Northern Virginia Technology Council report on information technology challenges in VA that indicated across the board hiring of needed staff proceeds too slowly. “The causes are complex, but much of the delay can be traced to redundant, inconsistent, and inefficient hiring processes.”⁵³⁴ One driver of extended VHA hiring times is the government background checks and the licensing and credential review for clinical staff that is managed through VetPro, an internet-enabled data bank for credentialing VHA personnel.⁵³⁵

Although addressing recruiting and hiring problems will not be easy, doing so is essential to maintaining VHA’s workforce.⁵³⁶ An internal VHA workgroup that examined HR concluded that a complete break with Title 5 and a reworking of current Title 38 hiring authority is required, stating:

*The existing Personnel system does not meet today’s market or demand. With VHA’s tremendous volume of occupations to hire and significant turn-over rate in critical positions, it is necessary to promote an efficient organizational system to be able to hire qualified candidates as quickly as possible. The current classification system led to disparity across the systems and only looks at the duties of the position versus the qualifications of the person. The VHA hiring system must be agile and attractive to recruit those that just graduated or are entering the workforce... An agency specific excepted employment system would allow VHA to meet the unique staffing demands that are required of a complex health care organization.*⁵³⁷

VHA is Not Competitive in Pay for Many Positions

Many VHA staff have substantially lower earning potential than their private-sector counterparts. Despite a generous benefits package and the possible opportunities for greater work-life balance, and for research and teaching in a system that serves the important role of caring for the nation’s veterans, lower salaries reduce VHA’s competitive edge in the marketplace when trying to attract top talent.⁵³⁸ For example, although VHA is often able to provide physicians an entry salary that is comparable or better than industry standards, physicians’ long-term earning potential is dramatically less in VHA than that of their private-sector peers. “At the top of the salary ranges, VHA providers made less than their counter parts

⁵³³ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow-Clinical)*, 45-49, accessed May 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

⁵³⁴ Northern Virginia Technology Council, *Opportunities to Improve the Scheduling of Medical Exams for America’s Veterans*, 12, accessed April 25, 2016, <http://www.va.gov/opa/choiceact/documents/NVTCFinalReporttoVA-revised3.pdf>.

⁵³⁵ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 37, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵³⁶ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵³⁷ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵³⁸ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 39, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

by up to \$310,000 and on average, \$74,631. The only specialties for which VHA physicians made equal to or more than industry averages were anesthesiology, nephrology, ophthalmology, and psychiatry.”⁵³⁹ In another example of barriers to competitive pay, current provisions in law limit VA to a 60 percent level of market pay compensation for allied health professionals, even when recruitment failures demonstrate the need to offer higher salaries.⁵⁴⁰ As noted above in the discussion on classification, failure to appropriately classify positions also leads to a salary that is not competitive with private-sector health care organizations for positions such as customer service personnel.

In the area of educational debt repayment relief, VHA lags behind other federal and state agencies that use such programs to fill critical physician shortages in medically under-served areas.⁵⁴¹ VHA can offer up to a maximum of \$60,000 for 2 years (\$30,000 per year). HRSA National Health Service Corps (NHSC) runs three programs: the NHSC loan repayment program that provides up to \$50,000 in loan payments, the Student-to-Student Loan Repayment Program for up to \$120,000, and the State Loan Repayment Program with each state establishing loan amounts that are administered by HRSA.⁵⁴² These amounts range broadly from \$80,000 in Arizona and Arkansas, \$90,000 in Colorado, \$100,000 in Georgia and Alabama, and \$190,000 in California.⁵⁴³

Clinic Staffing Is Impaired by Current Law, Regulation, and Policy

Successfully reallocating staff to meet veterans’ needs in a rapidly evolving health care environment is difficult in VHA. The *Independent Assessment* recommended that VHA use extended clinic hours and weekend clinics to better optimize space and increase access to care for veterans.⁵⁴⁴ VA policy currently prohibits full-time VA physicians from receiving fee-basis compensation from the same VA facility in which they are salaried, although they can, under certain circumstances, receive fee-basis appointments at other VA facilities.⁵⁴⁵

These restrictions can make it hard to meet policy requirements for night and weekend schedules⁵⁴⁶ without reducing staffing on inpatient units or under-resourced primary care clinics. Use of alternative work schedules and overtime pay for physicians to meet local patient demands should be under control of local medical center directors.

⁵³⁹ Ibid., 40.

⁵⁴⁰ Increases in Rates of Basic Pay, 38 U.S.C. § 7455.

⁵⁴¹ Joleen Clark, Jack Hetrick, and Donna Schroeder, Veterans Health Administration Leading Access Scheduling Initiative – People, *Alternative Personnel System Workgroup Report*, August 2014.

⁵⁴² “Loan Repayment Program,” U.S. Department of Health and Human Services, National Health Service Corps, accessed June 9, 2016, <http://nhsc.hrsa.gov/loanrepayment/>.

⁵⁴³ “Physician Loan Repayment Guide,” Jimmy Karnezis, accessed April 13, 2016, <https://www.credible.com/blog/physician-loan-repayment-guide/>.

⁵⁴⁴ Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, 136, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

⁵⁴⁵ VA Handbook 5005, pt. II, ch. 3, § A, para. 3b.

⁵⁴⁶ Extended Hours Access for Veterans Requiring Primary Care Including Women’s Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics, VHA Directive 2013-001 (2013).

COMMISSION ON CARE FINAL REPORT

VHA Staff Receive Inadequate Training Including at Initial Hire

Leading practices include providing mandatory onboarding training that introduces policies, procedures, and necessary skills. Onboarding programs include various activities that expose new hires to the culture of the organization and expectations based on roles and responsibilities. A report released by the Society for Human Resources Management suggests, “Formal orientation programs help new employees understand many important aspects of their jobs and organizations, including the company’s culture and values, its goals and history and its power structure.”⁵⁴⁷ To make up for inadequate on-boarding and to fill current staff’s understanding of VA, VHA is providing VA 101 training for current employees, with 60 facilities having completed the training in FY 2015.⁵⁴⁸ Employees in VA continue to desire a wide array of training, including customer service training, professional development, peer-to-peer training, hands-on training, and role-specific training.⁵⁴⁹

HR Professionals Must Focus on People and Business Priorities Not Compliance

VHA job candidates indicate they have unsatisfactory recruiting experiences, noting failures in timely follow-up and communication.⁵⁵⁰ VA human resources management and administration indicate that VA HR professionals do not exhibit a uniform level of competency, frequently do not understand the employee recruitment process end-to-end, and fail to provide high quality consultative support to managers with respect to all HR functions, but particularly in the area of progressive discipline and firing of employees.⁵⁵¹ Currently HR professionals in VA are largely focused on compliance with a complex set of rules,⁵⁵² rather than adding true value to the organization and being able to be full partners in accomplishing VHA business objectives. Resolving these staffing issues would render the overall HR function more effective.

VHA must become the employer of choice to attract and retain the very best health care workforce. To help it accomplish this goal, VHA requires competitive pay and flexible hiring and talent management processes. VHA cannot achieve that goal within its current personnel systems. A uniform alternative personnel system under Title 38 for all VHA human capital management would accomplish all of the following:

- Meet the unique staffing demands of a health care delivery organization.
- Allow market-based compensation and pay-setting latitude using broad pay bands to support staff growth and progression within their job. VHA must consider total compensation (with benefits), as compared to market rates because the government provides many more benefits than private-sector organizations. Consequently, VA may

⁵⁴⁷Talya Bauer, Society for Human Resource Management, *Onboarding New Employees: Maximizing Success*, 2010, 9-10, accessed May 13, 2016, <https://www.shrm.org/about/foundation/products/documents/onboarding-percent20epg-percent20final.pdf>.

⁵⁴⁸ Veterans Health Administration, *Blueprint for Excellence: Fiscal Year 2015 Results: Communicating Accomplishments*, presented to the National Leadership Committee, March 22, 2016.

⁵⁴⁹ “MyVA, Putting Veterans First,” MyVA Advisory Committee (MVAC), Meeting #4, February 1-2, 2016, 103.

⁵⁵⁰ McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed April 13, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁵² Ibid.

pay less than private-sector employers for a position, but the total compensation (with benefits) may end up being equivalent to private-sector total compensation.

- Allow flexibility in the processes used to hire staff including direct hiring when needed.
- Support career planning and professional development through the application of competency models and training specific for health care as part of position management.
- Simplify the management tasks for supervisors and hiring managers who will only need to know one set of rules and processes instead of four.
- Simplify the job of HR professionals who will only need to know one set of rules and processes instead of four.
- Allow development and training of the HR workforce in VHA to focus on only one personnel system to create true end-to-end hiring expertise.
- Reduce competition within government where shortages of HR professionals create competition for Title 5 trained HR professionals.
- Create streamlined and uniform standards and approach to discipline and dismissal.
- Create fairness among staff in sick leave, vacation pay, salary, awards and bonuses, and compensatory time off.
- Support flow of staff between the field and VHA Central Office (VHACO) under a single personnel system.

Establishing a new human capital management system in VHA will neither be easy nor quick, nor will it be a panacea that alone will fix all that is wrong with recruitment, retention, development, and advancement. In designing and implementing a new system, VHA must take full advantage of private-sector resources and expertise in human resource management and ensure that the new system is built to be compatible with the private-sector. As VHA moves toward greater integration of care delivery, with networks of community providers, compatibility in personnel systems and a resulting greater flow of employees between VHA and community sites can help create closer linkages between the two parts of the care delivery system.

Implementation

Legislative Changes

- Create a simple-to-administer alternative personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector.
- Update student loan reimbursement limits to be competitive with other federally administered programs and market conditions.

COMMISSION ON CARE FINAL REPORT

- Establish an appeals process that provides staff appropriate due process that is based on the regulatory standards for the new alternative personnel system.

VA Administrative Changes

- Eliminate barriers to creating hiring pools for positions with frequent turnover (e.g., extend the length of time over which candidates can continue to be hired from a completed certification until all of the qualified candidates are hired or have declined offers).
- Eliminate barriers to initiating a recruitment process when vacancies are anticipated; positions need not be empty before recruitment ensues. In some cases, hires should also be made before the departure of key personnel to allow for on-the-job training and mentoring of the replacement.
- Benchmark credentialing to private-sector processes and consider outsourcing the process as much as practicable through centralized mechanisms.
- Release market pay and total compensation information to the field for all job categories using commercially available data and information, at least every 2 years.

Other Department and Agency Administrative Changes

- OPM should continue to oversee and administer benefits for VHA but not impose any of the other existing conditions or requirements on the management of the new alternative personnel system. The new personnel system should be governed by the new legislative requirements and those established during the anticipated rulemaking process in VA. These requirements include market-based pay, performance awards, or performance and disciplinary processes other than those imposed under Title 38.

Recommendation #16: Require VA and VHA executives to lead the transformation of HR, commit funds, and assign expert resources to achieve an effective human capital management system.

Problem

Effective planning for and management of human capital are core enabling requirements for any organization. If the system that supports the employees fails, then the organization fails. Executive leaders must ensure the success of human capital management; however, for too long in VA, human capital management has not been a top priority for leadership time, attention, and funding support. Human capital management personnel must be equal members of the leadership team, contributing fully to strategic decisions and planning for future initiatives.

Background

As recognized by GAO, “to attain the highest level of performance and accountability, federal agencies depend on three enablers: people, process, and technology. The most important of these is people, because an agency’s people define its character and its capacity to perform.”⁵⁵³ Human capital management, although often viewed as a cost, must be viewed as an investment in business success.⁵⁵⁴ For too long, VA human capital management has been undervalued and under resourced. A 1993 report from GAO outlined many of the same deficiencies found in 2016: a focus on compliance instead of outcomes, a lack of proactive human capital planning and management, and a weak system of rewards and incentives to attract and retain qualified personnel.⁵⁵⁵

Today, VA Human Resources and Administration (HRA) shares responsibility for human capital management with VHA. Neither organization has been able to establish a high-performing, effective, human capital management system. For VHA to transform to a high-performing organization, human capital management must do the same.

Analysis

VA “needs a fundamental overhaul of the core support functions (including human resources) . . . to increase responsiveness and efficiency and improve customer service. These functions should be aligned with the needs of the VHA organizations delivering care to

The Commission Recommends That . . .

- VHA hire a chief talent leader who holds responsibility for the operation’s entire HR enterprise, is invested with the authority and budget to accomplish the envisioned transformation, and reports directly to the CVCS.
- VA and VHA prioritize the transformation of human capital management with adequate attention, funding, and continuity of vision from executive leaders.
- VA align HR functions and processes to be consistent with best practice standards of high-performing health care systems.
- VA Human Resources and Administration and the Office of Information and Technology should create an HR information technology plan to support modernization of the HR processes and to provide meaningful data for tracking, quality improvement, and accountability.

⁵⁵³ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 3, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

⁵⁵⁴ Ibid.

⁵⁵⁵ U.S. General Accountability Office, *Management of VA: Improved Human Resource Planning Needed to Achieve Strategic Goals*, GAO/HRD-93-10, March 1993, accessed June 10, 2016, <http://www.gao.gov/assets/220/217512.pdf>.

COMMISSION ON CARE FINAL REPORT

Veterans.”⁵⁵⁶ Governance and responsibility for human capital management is fragmented and complicated.⁵⁵⁷ Medical center directors appear to be largely on their own in addressing human capital management needs, without competent and timely assistance to support hiring employees, planning for succession, and taking disciplinary actions.⁵⁵⁸ Recruiting takes too long and is cumbersome because information is not shared freely among the various organizational components.⁵⁵⁹ Candidates are not treated with respect, experience lengthy intervals between contacts from VA, fail to receive timely follow-up once candidates are selected, and experience a lengthy on-boarding process.⁵⁶⁰ Human capital management also fails to effectively support the disciplinary process, which is perceived as too long and too difficult.⁵⁶¹ Insufficient resources are devoted to training,⁵⁶² leaving VHA vulnerable to failure.

VA requires a comprehensive redesign of the human resources function to be more responsive, more efficient, and more focused on customer service.⁵⁶³ Transforming HR will require “redesigning key processes, shifting the mindset of [human resources] staff from compliance to effectiveness, training [human resources] and its customers on key roles and responsibilities, and rationalizing its technology systems.”⁵⁶⁴

Some progress has been made in updating human capital management functions. VA is in the process of implementing new talent management software to provide better process management and analytics.⁵⁶⁵ HRA has also started a new HR Academy.⁵⁶⁶ The academy is intended to demonstrate alignment between training resources and competency requirements⁵⁶⁷ and to describe the experience needed to advance to the next position level in human resources.⁵⁶⁸ VA instituted a new online senior executive service performance management system that permits real-time tracking of the performance management process and analysis of

⁵⁵⁶ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 37, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁷ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁵⁸ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L3, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁵⁹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 109, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁶⁰ *Ibid.*, 110.

⁵⁶¹ *Ibid.*, 61.

⁵⁶² *Ibid.*, 67.

⁵⁶³ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, L5, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁵⁶⁴ *Ibid.*

⁵⁶⁵ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁶⁶ *Ibid.*

⁵⁶⁷ Department of Veterans Affairs, HR Academy, *TMS User eIDP Checklist*, accessed January 25, 2016, www.vahracademy.va.gov/docs/TMSUserIDPChecklist.pdf.

⁵⁶⁸ “VA HR Academy: Resources,” Department of Veterans Affairs, accessed January 25, 2016, www.vahracademy.va.gov/resources.asp. Department of Veterans Affairs, *VA HR Competency Model Reference Guide*, accessed January 25, 2016, www.vahracademy.va.gov/docs/VAHRCompetencyModelReferenceGuide.pdf.

performance outcomes;⁵⁶⁹ however, HR specialists must still use as many as 30 different IT systems that do not communicate with each other to do their work.⁵⁷⁰ Although some new systems have been purchased, life cycle funding for them is not guaranteed by the Office of Information and Technology and no concrete plan has been approved to replace and consolidate the many current systems that are not interoperable. In addition, funding support for HRA initiatives overall are not planned, allocated, and maintained at consistent levels year-to-year in the departmental budget, impeding long term transformation.⁵⁷¹

A VHA workgroup was formed with HR subject matter experts and leadership to identify hiring barriers and develop recommendations for improvements. The workgroup fielded a survey in July 2014 to gather broad input from VHA on the deficiencies in the management of human capital in VHA. These experts concluded that VHA should move to a new alternative personnel system under Title 38.⁵⁷² (See Recommendation #15.)

Substantial deficiencies in human capital management still remain in VA. The funding mechanism to support the departments' human capital management does not support long-range planning and effective program implementation. The lines of authority and management for human capital management professionals do not permit consistency in the quality and skill of the human capital management professionals hired and promoted, nor does the reporting structure allow HRA to hold human capital management staff accountable for effective service delivery. The investment in human capital management information technology systems has been inadequate for decades.⁵⁷³

Top leadership, including the SECVA, DEPSECVA, and CVCS, must make the transformation of human resources a top priority as demonstrated by investing their personal time in human capital management transformation; reviewing and endorsing a transformation plan including the funding required to accomplish it; receiving regular progress updates; and engaging in problem-solving sessions with human capital management leaders to refine and advance transformation efforts. Top leadership must demonstrate to other leaders that human capital management transformation is an organizational priority by disseminating clear goals for transformation in planning documents, communicating expectations for change that are clear to all key employees, and sharing successes with subordinate leaders and employees. The CVCS must ensure that the executive who leads the human capital management function has the demonstrated knowledge, skills, and experience in human capital management to competently lead the function and make this individual part of the executive leadership team on par with other key functions like finance and clinical operations. (See suggested organization chart in Recommendation #12.)

⁵⁶⁹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷⁰ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, 24, 110, accessed January 26, 2016, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

⁵⁷¹ Sam Retherford, Principal Deputy Assistant Secretary for Human Resources and Administration, Department of Veterans Affairs, speaking to the leadership workgroup of the Commission on Care, December 15, 2015.

⁵⁷² Ibid.

⁵⁷³ Ibid.

COMMISSION ON CARE FINAL REPORT

The SECVA, DEPSECVA, and CVCS must engage subordinate leaders in the transformation process by ensuring the needs of these leaders have informed the transformation solutions; that subordinate leaders are assigned specific responsibilities under the transformation plan; and they are held accountable by the CVCS for outcomes. They must also ensure that the HR transformation and ongoing HR function is adequately resourced to be successful.

The VA HRA and VHA Workforce Management Office must engage change management experts to undertake a review of human resource business processes, management structures, funding, and technology needs to create a transformation agenda and human capital management plan. As VHA is shifting to a new alternative personnel system under Title 38, the human capital management plan should consolidate in VHA the HR functions, responsibility, and authority required to hire, manage, develop, reward, and discipline staff and consider whether functions such as benefit management remain with HRA or move to VHA. Furthermore, the plan should address all of the following issues:

- need for a chief of talent management
- consistency with benchmark standards of private-sector health care systems
- key organizational structures and roles and responsibilities of VA and VHA in human capital management that are clearly defined and consistent with benchmark organizations
- the full life cycle of human capital management (i.e., planning, recruitment, hiring, retention, development, performance management, and discipline), which should be supported effectively by human capital management and fully meet the needs of managers and staff
- federal sharing authority and the ability to outsource human capital management functions to the private sector are addressed
- IT investments and analytical capability to provide meaningful, timely data to managing staffing, performance tracking, and accountability
- meaningful performance metrics and risk management indicators that are established for human capital management⁵⁷⁴
- funding and full-time equivalent employee staffing for human capital functions that meet private-sector benchmark standards for health care
- knowledge, skills, and ability required of human capital management professionals at each grade and within each series, which should be clearly defined, and a requirement to assess current staff, new hires, and promotions against this standard, which should include procedures for dismissal

⁵⁷⁴ U.S. General Accountability Office, *Human Capital: A Self-Assessment Checklist for Agency Leaders*, GAO/OCG-00-14G, version 1, September 2000, 34, accessed June 10, 2016, <http://www.gao.gov/assets/80/76520.pdf>.

Once completed, this analysis and draft plan must be shared widely within the department to gain feedback and input, and it must be shared with OPM, OMB, and Congress. After incorporating feedback and finalizing the plan, HRA should engage change management experts to fully implement the transformation agenda and new human capital management plan. Implementation will require funding contributions from VA and VHA that the SECVA must mandate.

HRA must develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES). This process must include clear standards, guidelines, and training for supervisors and managers on how to implement the new progressive discipline process. All managers and supervisors and human capital management professionals must complete the training, and VA must establish a process for ensuring that new supervisors and managers complete the training on an ongoing basis. HRA must develop HR staff to be effective coaches so they can provide the coaching and support that managers need as they embark on disciplinary procedures to ensure timely and effective interventions.

VHA supervisors and managers must be held accountable for applying these procedures when poor performance or conduct occurs. To enable accountability, VHA must have a technology infrastructure to actively track and manage poor performance (annual ratings and disciplinary actions) that both human capital managers and supervisors can use to keep track of issues.

The Commission notes GAO is launching a comprehensive audit of human capital management functions in VA to be delivered to Congress in September 2016.⁵⁷⁵ The review and resulting recommendations will provide further insights to promote meaningful transformation of human capital management in VHA.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

The following administrative changes are a priority over the next 36 months. To assist VHA in implementing these actions and to promote accountability and oversight, the Commission has provided a detailed timeline and assigned responsibility for action in Appendix B.

- Employ HR and change management experts to undertake a review of its business processes, management structures, funding, technology, and the legal authority needed in HR to create a transformation agenda and human capital management plan.
- Require VHA to allocate budget to fully support the change plan and ongoing HR operations.

⁵⁷⁵ Ms. Frieda Stenzel, lead investigator, U.S. Government Accountability Office, during an initial meeting with VACO HR&A about a new study being undertaken by GAO, December 18, 2015. The study is intended to 1) assess VHAs capacity to perform its workforce planning and talent management, and 2) evaluate the effectiveness of VHAs human capital functions.

COMMISSION ON CARE FINAL REPORT

- Develop and implement an effective progressive discipline process for all staffing authorities.

Other Department and Agency Administrative Changes

- None required.

Eligibility

Recommendation #17: Provide a streamlined path to eligibility for health care for those with an other-than-honorable discharge who have substantial honorable service.

Problem

Addressing access issues is at the core of the Commission's charge. Veterans face a range of barriers to care, from geographic barriers to facility-specific problems, such as long wait times for an appointment or lack of evening or weekend hours. These barriers,

which affect even those with service-incurred health conditions, can be overcome. Some former service members, however, have encountered a more fundamental barrier when applying for care. Because of the character of their discharge, they are not considered veterans, and thus are not eligible for VA care.

The Commission Recommends That . . .

- VA revise its regulations to provide tentative eligibility to receive health care to former service members with an other-than-honorable discharge who are likely to be deemed eligible because of their substantial favorable service or extenuating circumstances that mitigate a finding of disqualifying conduct.

In some cases, individuals have been dismissed from military service with an other-than-honorable (OTH) discharge because of actions that resulted from health conditions (such as traumatic brain injury, posttraumatic stress disorder [PTSD], or substance use) caused by, or exacerbated by, their service. Under VA regulations, these individuals do not meet the definition of a veteran, and are therefore ineligible for VHA medical care. This situation leaves a group of former service members who have service-incurred health issues (namely mental health issues) unable to receive the specialized care VHA provides.

Background

Veteran status is the basis for eligibility for all VA benefits,⁵⁷⁶ and under law a veteran is a person who has met three criteria: active-duty military service (subject to specified exceptions), 2 years of continuous service, and discharge or separation from the military under conditions other than dishonorable.⁵⁷⁷ The military characterizes discharges into one of five categories: honorable, general (under honorable conditions), OTH, bad conduct (adjudicated by a general court or special court-martial), and dishonorable.⁵⁷⁸

Congress has established specific bars to VA benefits. Those barred by statute include deserters, individuals sentenced by a general court-martial, and conscientious objectors who refused to perform military duty.⁵⁷⁹ VA regulations interpret the phrase "discharged or released . . . under conditions other than dishonorable" to mean that a discharge or release because of one of the following offenses is considered to have been issued under dishonorable conditions:

(1) acceptance of an OTH discharge to escape trial by general court-martial, (2) mutiny or

⁵⁷⁶ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁷ Veterans Benefits, 38 U.S.C. § 101(2).

⁵⁷⁸ Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁷⁹ Certain Bars to Benefits, 38 U.S.C. § 5303(a).

COMMISSION ON CARE FINAL REPORT

spying, (3) an offense involving moral turpitude, (4) willful and persistent misconduct, and (5) certain homosexual acts involving aggravating circumstances.⁵⁸⁰

Limited exceptions to those statutory and regulatory bars permit VA to award of benefits. A claimant may be granted benefits if VA determines that the claimant was insane at the time of the offense leading up to discharge.⁵⁸¹ Benefits may be granted based on a prior period of other-than-dishonorable service for individuals with two or more periods of service.⁵⁸²

Former service members with an OTH discharge as a result of a regulatory (rather than a statutory) bar are eligible for VA care for service-incurred conditions.⁵⁸³ Former service members with OTH discharges are not recognized as veterans, so they will be routinely denied treatment unless they initiate, and prevail in, an adjudication conducted by the Veterans Benefits Administration as to the character of their discharge. No routine mechanism exists to trigger adjudication to determine if such a discharge is not dishonorable. In many instances, the character of an individual's discharge is predicated on behaviors that resulted from, or are linked to, behavioral health conditions that had their origin in service, yet VA regulation bars the individual from receiving benefits.⁵⁸⁴

Analysis

Veterans' benefits are understood to be earned. The principle has been described as follows: In harsh environments in which lives may be on the line, serious breaches of conduct that interfere with the military mission should rightfully brand the offender for life and should likewise prohibit them from being eligible for the special military benefits and entitlements reserved for honorable and meritorious service.⁵⁸⁵

Some argue the offender's mental state at the time of the misconduct must be taken into account when considering veteran status.⁵⁸⁶ For example, many service members have experienced combat and sustained psychological wounds of war that manifest behaviors that lead to military discipline.⁵⁸⁷ VA regulations not only fail to account for the role of those psychic wounds, but are themselves overbroad, weak discriminators as to what is truly dishonorable service. To illustrate, commentators have identified two regulatory bars as particularly problematic: those based on moral turpitude,⁵⁸⁸ and willful and persistent misconduct.⁵⁸⁹ Neither of those two regulatory terms, which originated in 1944,⁵⁹⁰ are defined; neither provides

⁵⁸⁰ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸¹ Certain Bars to Benefits, 38 U.S.C. § 5303(b).

⁵⁸² Congressional Research Service, *Veterans' Benefits: The Impact of Military Discharges on Basic Eligibility*, 3, accessed May 26, 2016, <https://www.fas.org/sgp/crs/misc/R43928.pdf>.

⁵⁸³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁵⁸⁴ Certain Bars to Benefits, 38 U.S.C. § 5303(a). Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁵ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 12-13, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁸⁶ *Ibid.*, 13.

⁵⁸⁷ *Ibid.*

⁵⁸⁸ Characters of Discharge, 38 C.F.R. 3.12(d).

⁵⁸⁹ *Ibid.*

⁵⁹⁰ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the

criteria or examples of what is or is not covered. Both are ambiguous and susceptible to subjective judgment,⁵⁹¹ with great potential for different VA regional offices reaching different outcomes on the same facts.⁵⁹² VA officials have acknowledged that these terms are broad and imprecise,⁵⁹³ and advocates have documented the resultant disparities in VA adjudicative decisions.⁵⁹⁴

The only specific mental-health exception to the bar-to-benefits rules — that the person was insane at the time of the commission of offense⁵⁹⁵ — is very limited. VA regulations define the term *insane*, as follows:

*An insane person is one who, while not mentally defective or constitutionally psychopathic, except when a psychosis has been engrafted upon such basis condition, exhibits, due to disease, a more or less prolonged deviation from his normal method of behavior; or who interferes with the peace of society; or who has so departed (become antisocial) from the accepted standards of the community to which by birth and education he belongs as to lack the adaptability to make further adjustments to the social customs of the community in which he resides.*⁵⁹⁶

VA's Office of General Counsel (OGC), in a now almost 20-year old precedential opinion, has construed that regulation narrowly. Responding to a request for an opinion regarding the parameters for behavior that would constitute insanity under the regulation, the General Counsel advised, as follows:

*The question of insanity arises in numerous legal proceedings, and its meaning may vary according to the jurisdiction and the object or purpose of the proceeding. However, in all contexts, the term indicates a condition involving conduct which deviates severely from the social norm. Black's Law Dictionary, at 794, states that '[t]he term is more or less synonymous with . . . psychosis, which itself has been defined as "a mental disorder characterized by gross impairment in reality testing' or, in a more general sense, as a mental disorder in which 'mental functioning is sufficiently impaired as to interfere grossly with the . . . capacity to meet the ordinary demands of life.'*⁵⁹⁷

Armed Forces," *Military Law Review*, 214, Winter, (2012): 160-192, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹¹ Ibid., 164, 186.

⁵⁹² Ibid., 10, 172. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable*, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹³ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 67, accessed June 25, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁵⁹⁴ Ibid., 68-70.

⁵⁹⁵ Characters of Discharge, 38 C.F.R. 3.12(b).

⁵⁹⁶ Determinations of Insanity, 38 C.F.R. 3.354(a).

⁵⁹⁷ "Office of General Counsel: Opinions Year 1997," U.S. Department of Veterans Affairs, accessed June 15, 2016, <http://www.va.gov/ogc/opinions/1997precedentopinions.asp>. Vet. Aff. Op. Gen Couns. Prec. 20-97, VAOPGCPREC 20-97, 1997, accessed June 15, 2016, <http://www.va.gov/ogc/docs/1997/Prc20-97.doc>.

COMMISSION ON CARE FINAL REPORT

As understood by VA OGC at the time, *insanity*, with its emphasis on gross impairment, and as reflected in practice,⁵⁹⁸ is a highly restrictive standard. That narrow standard is also limiting with respect to the range of symptoms that could be considered under the *insanity* exception: gross cognitive impairment or gross impairment in capacity to function in daily life. That limited range effectively excludes behaviors associated with a widely prevalent service-related condition, PTSD. Those behaviors, which often lead to disciplinary actions, include aggressive behavior, substance-abuse,⁵⁹⁹ impulsivity, and risk-taking (including sensation seeking, aggressive driving, interpersonal violence, and self-injurious or suicide-related behavior).⁶⁰⁰ Research has shown that combat veterans with PTSD and other psychiatric diagnoses have a heightened risk of misconduct outcomes.⁶⁰¹ Other than its *insanity* rule, the regulations provide no specific opportunity to consider mental health as a likely cause of, or mitigating factor in, disciplinary issues leading to an individual's discharge.

The following are illustrative examples of how these regulations have worked in practice:

- John, a service member with multiple deployments to Iraq and Afghanistan and 7 years of service, received an OTH discharge after self-medicating with marijuana. He was denied VA treatment for PTSD.⁶⁰²
- Tim, a rifleman with two purple hearts and four campaign ribbons for service in Vietnam, was sent to combat while still 17 years old, and had a nervous breakdown and suicide attempt before his 18th birthday. He was sent back to Vietnam involuntarily for a second tour, and had a third nervous breakdown that led to an AWOL and OTH discharge. He was denied service connection for PTSD because the nature of his discharge.
- Tom, a combat infantryman in the first Gulf War, on his return, started experiencing symptoms of PTSD and attempted suicide. He was denied leave to be with his family,

⁵⁹⁸ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable,"* accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁵⁹⁹ Deirdre MacManus et al., "Aggressive and Violent Behavior Among Military Personnel Deployed to Iraq and Afghanistan: Prevalence and Link with Deployment and Combat Exposure," *Epidemiologic Reviews*, 37, no. 1, (2015): 196-212, <http://doi.org/10.1093/epirev/mxu006>.

Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰⁰ Lisa M. James, Thad Q. Strom, and Jennie Leskela, "Risk-Taking Behaviors and Impulsivity Among Veterans With and Without PTSD and Mild TBI," *Military Medicine*, 179, no. 4, (2014): 357 – 363, <http://publications.amsus.org/doi/pdf/10.7205/MILMED-D-13-00241>.

⁶⁰¹ Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, <http://dx.doi.org/10.1186%2F1471-244X-10-88>.

⁶⁰² Swords to Plowshares, presentation to Commission on Care, January 21, 2016, accessed June 25, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former service members.

but left anyway. After a 60-day absence, he returned and was given an OTH discharge. He was denied services for 20 years.⁶⁰³

In short, the VA regulation used to determine whether the character of a veteran's OTH discharge is disqualifying does not take into account behavioral health problems associated with military service. As a result, former service members who were discharged for disciplinary problems that cannot be disassociated from PTSD or other behavioral health disorders are routinely barred from VA treatment for those disorders.

Individuals with PTSD and traumatic exposure are at heightened risk of substance abuse,⁶⁰⁴ depression,⁶⁰⁵ homelessness,⁶⁰⁶ premature mortality,⁶⁰⁷ and suicide.⁶⁰⁸ Access to VA health care is vital to successful reintegration of combat-traumatized veterans into society because it provides "the only reservoir of combat PTSD expertise."⁶⁰⁹

The importance of early access to needed treatment for behavioral health conditions like PTSD cannot be overstated,⁶¹⁰ yet many former service members are reluctant to seek treatment for behavioral health problems.⁶¹¹ Those with unfavorable discharge records who finally come forward to seek medical care must not only initiate a request for a character of discharge adjudication, but be prepared to confront a lengthy process if they elect to do so.⁶¹²

⁶⁰³ Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁰⁴ Kipling M. Bohnert et al., "The Association Between Substance Use Disorders and Mortality among a Cohort of Veterans with Posttraumatic Stress Disorder: Variation by Age, Cohort, and Mortality Type," *Drug and Alcohol Dependence*, 128, no. 1-2, (2013): 98-103, <http://www.sciencedirect.com/science/article/pii/S0376871612003328>.

⁶⁰⁵ Leo Sher, Maria Dolores Braquehais, and Miquel Casas, "Posttraumatic Stress Disorder, Depression, and Suicide in Veterans" *Cleveland Clinic Journal of Medicine*, 79, no. 2 (2012): 92-97, <http://doi.org/10.3949/ccjm.79a.11069>.

⁶⁰⁶ Eve B. Carlson et al., "Traumatic Stressor Exposure and Post-Traumatic Symptoms in Homeless Veterans," *Military Medicine*, 178, no. 9, (2013): 970-973, <http://doi.org/10.7205/MILMED-D-13-00080>.

⁶⁰⁷ Joseph A. Boscarino, "Posttraumatic Stress Disorder and Mortality Among U.S. Army Veterans 30 Years After Military Service," *Annals of Epidemiology*, 16, no. 4 (2005): 248-256, <http://www.sciencedirect.com/science/article/pii/S1047279705001109>.

⁶⁰⁸ Holly J. Ramsawh et al., "Risk for Suicidal Behaviors Associated with PTSD, Depression, and their Comorbidity in the U.S. Army," *Journal of Affective Disorders*, 161, no. 1, (2014): 116-122, <http://www.sciencedirect.com/science/article/pii/S0165032714001189>.

⁶⁰⁹ Major John Brooker, Major Evan R. Seamone, and Leslie C. Rogall, "Beyond 'T.B.D.': Understanding VA's Evaluation of a Former Servicemember's Benefit Eligibility Following Involuntary or Punitive Discharge from the Armed Forces," *Military Law Review*, 214, Winter, (2012): 14, accessed June 20, 2016, https://www.loc.gov/rr/frd/Military_Law/Military_Law_Review/pdf-files/214-winter-2012.pdf.

⁶¹⁰ Ronald C. Kessler, "Posttraumatic Stress Disorder: The Burden to the Individual and to Society," *Journal of Clinical Psychology*, 5, Suppl. 5, (2000): 4-12, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/10761674>.

⁶¹¹ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶¹² Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 74-78, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

COMMISSION ON CARE FINAL REPORT

Several generations of former service members were exposed to combat trauma and continue to live with the psychological wounds of war. Lack of access to treatment for those who sustained psychological wounds that went untreated and were manifest in undesirable behavior in service is concerning. Although Congress could address this concern, VA has the means to remedy the problem without congressional action by amending its own regulations. VA could afford former service members needed treatment for their conditions when they are able to establish that their health problems were incurred in service.⁶¹³ In other circumstances, when it is likely an individual could establish eligibility for VA care, current regulation permits the individual to receive the care on the basis of a tentative eligibility determination.⁶¹⁴ This regulation permits VA to provide treatment without prior adjudication of the character of discharge.

VA should revise its regulations to lift the immediate bar to health care for former service members who have an OTH discharge. VA should award tentative eligibility for health care to at least some former service members who have an OTH discharge. The criteria for awarding tentative eligibility for care could include service in a combat theater, more than a single enlistment, duration of service, or some combination thereof. This approach would allow VA to provide meaningful access to treatment without delay for those likely to be granted eligibility. For health care purposes, VA should also revise its regulations by recognizing that the severe punishment of characterizing a person's service as OTH is not justified when extenuating circumstances (to include behavioral health issues at the time) explain or mitigate that misconduct that resulted in the OTH discharge.

Implementation

Legislative Changes

- None required.

VA Administrative Changes

- Amend 38 C.F.R. 17.34 to provide for tentative eligibility determinations applicable to individuals with OTH discharges who have had substantial honorable service, including service in a combat theater.
- Amend of 38 C.F.R. 3.12(d) to provide for recognition of extenuating circumstances that show, for purposes of health care eligibility, that service was not OTH.

Other Departments and Agency Administrative Changes

- None required.

⁶¹³ Sec. 2, Pub. L. No. 95-126, 91 Stat. 1106 (1977).

⁶¹⁴ Tentative Eligibility Determinations, 38 C.F.R. 17.34.

Recommendation #18: Establish an expert body to develop recommendations for VA care eligibility and benefit design.

Problem

Although VHA continues to offer the promise of health care to all veterans, its capacity to meet that promise is constrained by appropriated funding.⁶¹⁵ Congress and VA leadership must work to identify who VHA will serve, and what services it will provide, yet eligibility criteria have not been examined in 20 years.⁶¹⁶

Background

VHA's core mission is to care for veterans who has borne the battle. But its secondary mission of caring for veterans' non-service-connected health care needs is longstanding, dating back to Civil War origins. Congress has included veterans without service-connected needs among those eligible as highlighted below:

The Commission Recommends That . . .

- The President or Congress task another body to examine the need for changes in eligibility for VA care and/or benefits design, which would include simplifying eligibility criteria, and may include pilots for expanded eligibility for nonveterans to use underutilized VHA providers and facilities, providing payment through private insurance.
- The SECVA revise VA regulations to provide that service-connected-disabled veterans be afforded priority access to care, subject only to a higher priority dictated by clinical care needs.

- In March 1865, Congress incorporated the National Home for Disabled Volunteer Soldiers and Sailors, originally intended for Union veterans who suffered economic distress from disabilities incurred during the Civil War. The National Home constructed the first hospitals for Civil War veterans in 1866, and after a series of acts of Congress, those hospitals were opened in 1887 to veterans suffering economic distress from disabilities not incurred in military service.⁶¹⁷
- The World War Veterans Act of 1924, which established the Veterans Bureau⁶¹⁸ (the predecessor to the Department of Veterans Affairs), authorized its director to provide hospitalization and related travel expenses to veterans whose services dated back as far as 1897, regardless of the type or cause of their disabilities, as long as those veterans who were unable to pay received preferential admission.⁶¹⁹
- Public Law 85-56 (1957), which codified prior VA laws and regulations, effectively expanded eligibility to veterans of future wars, providing needed hospital care for veterans with service-connected disability incurred or aggravated during war, or for any other disability if the veteran is unable to pay for hospital care.⁶²⁰

⁶¹⁵ The MITRE Corporation, *Independent Assessment of the Health care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 24, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶¹⁶ *Ibid.*, 25.

⁶¹⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 62.

⁶¹⁸ The Veterans Bureau consolidated the National Home and other veterans-related functions housed in different government bureaucracies.

⁶¹⁹ World War Veterans Act, 1924, Pub. L. No. 68-242, (1924).

⁶²⁰ Veterans Benefits Act of 1957, Pub. L. No. 85-56, 71 Stat. 83 (1957). That law provided separate authority in section 512 for outpatient medical treatment, which was limited to treatment for a service-connected disability.

COMMISSION ON CARE FINAL REPORT

- In 1966, Congress expanded eligibility for hospital care to *peacetime* veterans (of service after January 1955).⁶²¹
- In 1970, Congress extended eligibility for hospital care to veterans 65 and older for a non-service-connected disability,⁶²² exempting that group of veterans from taking the then-required oath affirming their inability to defray the expense of care for non-service-connect ailments.⁶²³
- With the Veterans Health Care Expansion Act of 1973, Congress eliminated the distinction between wartime and peacetime veterans for purposes of eligibility for outpatient care, and further expanded eligibility to outpatient care. It granted veterans who are 80 percent or more service-connected disabled eligibility for treatment of any condition, and authorized others eligible for hospital care to receive outpatient care to prepare for or preclude a need for hospitalization or to complete treatment initiated during hospitalization.⁶²⁴
- Congress expanded eligibility again in 1976, authorizing hospital care for treating a non-service-connected condition of any veteran 65 or older (without regard to ability to pay), authorizing outpatient care for any disability to any veteran 50 percent or more service-connected disabled, and directing VA to ensure, by regulation, special treatment priority to service-connected veterans and others receiving benefits because of a need for aid and attendance, or being permanently housebound.⁶²⁵

Eligibility laws for veterans' health care have changed substantially during the past century, yet the commitment to serving service-connected veterans and veterans in financial need has remained constant.

Prior to enactment of the Veterans' Health Care Eligibility Reform Act of 1996,⁶²⁶ VHA was a hospital-based model with entirely different eligibility rules for hospital care than for outpatient care. The eligibility reform law was aimed at transforming access to VA care from a 1950s hospital-based model to one that erased distinctions between eligibility for hospital and outpatient care.⁶²⁷ It essentially provided that all veterans are eligible for VA hospital care and *medical services*.⁶²⁸

⁶²¹ Veterans Readjustment Benefits Act of 1966, Pub. L. No. 89-358, 80 Stat. 12 (1966).

⁶²² Pub. L. No. 91-500.

⁶²³ S. Rep. No. 91-481.

⁶²⁴ Veterans Health Care Expansion Act of 1973, Pub. L. No. 93-82, 87 Stat. (1973).

⁶²⁵ Veterans Omnibus Health Care Act of 1976, Pub. L. No. 94-581, 90 Stat. 2842 (1976). The patchwork of eligibility provisions resulting from a succession of incremental changes set the stage for development and enactment of the Veterans' Health Care Eligibility Reform Act of 1996, Pub. Law 104-262.

⁶²⁶ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262, 110 Stat. 3177 (1996).

⁶²⁷ *Ibid.*

⁶²⁸ The term "medical services" was broadly defined to include in addition to medical examination and treatment, preventive health services; surgical services; wheelchairs, artificial limbs, and similar appliances; optometric and podiatric services; noninstitutional extended care services; and rehabilitative services (including services to restore physical, mental, and psychological functioning. Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1701(6),(8). VA regulations more fully set out the "medical benefits package" that VA is to provide patients, as needed; VA regulations detail that the benefits package includes services ranging from emergency care and prescription drugs to

Recognizing there could be circumstances in which VHA might lack capacity to provide timely care, Congress noted in the reform act that the requirement to provide care would be in effect only to the degree to which there were appropriated funds to pay for such care.⁶²⁹ This qualified availability of care clearly indicated veterans' health care is not an entitlement. Congress went further, though, and established a statutory patient enrollment mechanism for VA to manage access.⁶³⁰ The law specifically requires VA to establish and operate a patient enrollment system managed in accordance with statutory priorities and within any additional priority classifications established by VA. The eligibility reform act gave VA tools both to limit demand consistent with available funding and to discourage veterans from seeking VA care simply to fill an occasional need not met by a private health plan.⁶³¹ The act also requires the SECVA to manage the enrollment system such that care is timely and of acceptable quality.⁶³²

The enrollment system the department established is not being used today to calibrate supply and demand as envisioned.⁶³³ Although law and VA regulation require a system of annual patient enrollment,⁶³⁴ VHA last curtailed enrollment in 2003, and then only for veterans who were deemed eligible based on the category 8 criteria (see Table 8) that include those with higher-level incomes who lack any higher priority. In 2009, the Obama administration eased access for higher income veterans. Under that policy, veterans whose gross household income exceeds VA's current geographic income limit by 10 percent or less may enroll for VA care, subject to cost-sharing requirements.⁶³⁵ In 2014, Congress established the *Choice Program* to expand availability of care through contracts with community providers. Veterans' choice was limited by reference to distance and wait-time issues, but was otherwise broadly open to any enrolled veterans.⁶³⁶

comprehensive rehabilitative services, home health services, noninstitutional extended care services, hospice care, and pregnancy and delivery services and newborn care. Medical Benefits Package, 38 C.F.R. 17.38.

⁶²⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General 38 U.S.C. § 1710(a)(4).

⁶³⁰ Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705. As explained in the report of the House Committee on Veterans Affairs which developed the legislation, "[T]he Act would...provide the VA with an important tool, the authority to design and manage access to care through a system of patient enrollment...Enrollment...would help the VA plan more effectively, so that facilities can better calculate and dedicate the resources needed to provide the care its enrollees require. The Act would direct the Secretary...to establish and operate a system of annual patient enrollment and require that veterans be enrolled in a manner giving relative degrees of preference in accordance with specified priorities. At the same time, it would vest discretion in the Secretary to determine the manner in which such enrollment (or registration) system would operate. For example, the VA would be able to establish a system which simply registers patients throughout all or part of a fiscal year, or could employ a time-limited registration period. Significantly, the Act would permit the Secretary to set priorities within the specified priority classifications established in the Act. The Secretary could, for example, establish a policy which, within any priority classification, gives veterans who have previously been "enrolled" as VA patients priority over new applicants. However, the Committee expects any enrollment system to be designed and administered to assure that any veteran with a service-connected condition would receive priority treatment for that condition whether or not that veteran had enrolled for VA care." H. Rep. No. 104-690, 6-7.

⁶³¹ Veterans' Health Care Eligibility Reform Act of 1996, Pub. L. No. 104-262; 110 Stat. 3177 (1996).

⁶³² Management of Health Care: Patient Enrollment System, 38 U.S.C. § 1705(b).

⁶³³ H. Rep. No. 104-690, 16.

⁶³⁴ Enrollment, 38 C.F.R. sec. 17.36(c). VA regulations state that "[i]t is anticipated that that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled."

⁶³⁵ Enrollment, 38 C.F.R. 17.36(b)(8)(ii),(iv).

⁶³⁶ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014). Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Pub. L. No. 114-41 (2015).

COMMISSION ON CARE FINAL REPORT

Table 8. Priority Groups

Priority Group	Definition
1	<ul style="list-style-type: none"> ▪ Veterans with VA-rated service-connected disabilities 50% or more disabling ▪ Veterans determined by VA to be unemployable due to service-connected conditions
2	<ul style="list-style-type: none"> ▪ Veterans with VA-rated service-connected disabilities 30% or 40% disabling
3	<ul style="list-style-type: none"> ▪ Veterans who are former prisoners of war ▪ Veterans awarded a Purple Heart medal ▪ Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty ▪ Veterans with VA-rated service-connected disabilities 10% or 20% disabling ▪ Veterans awarded special eligibility classification under Title 38, U.S.C. § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation" ▪ Veterans awarded the Medal of Honor
4	<ul style="list-style-type: none"> ▪ Veterans who are receiving aid and attendance or housebound benefits from VA ▪ Veterans who have been determined by VA to be catastrophically disabled
5	<ul style="list-style-type: none"> ▪ Non-service-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income below VA's and geographically (based on resident zip code) adjusted income limits ▪ Veterans receiving VA pension benefits ▪ Veterans eligible for Medicaid programs
6	<ul style="list-style-type: none"> ▪ Compensable 0% service-connected veterans ▪ Veterans exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki ▪ Project 112/SHAD (shipboard hazard and defense) participants ▪ Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975 ▪ Veterans of the Persian Gulf War who served between August 2, 1990 and November 11, 1998 ▪ *Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987 ▪ Veterans who served in a theater of combat operations after November 11, 1998 as follows: <ul style="list-style-type: none"> – Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge. – **Combat veterans who were discharged between January 2009 and January 2011, and did not enroll in the VA health care during their five-year period of eligibility have an additional one year to enroll and receive care. The additional one-year eligibility period began February 12, 2015 with the signing of the Clay Hunt Suicide Prevention for America Veterans Act. <p>Note: At the end of this enhanced enrollment priority group placement time period veterans will be assigned to the highest Priority Group (PG) their unique eligibility status at that time qualifies for.</p> <p>*Note: While eligible for PG 6; until system changes are implemented you would be assigned to PG 7 or 8 depending on your income.</p> <p>*Note: While eligible for PG 6; due to system limitations, veterans will be manually assigned to PG 8c, yet eligible for the enhanced benefits</p>
7	<ul style="list-style-type: none"> ▪ Veterans with gross household income below the geographically-adjusted income limits for their resident location and who agree to pay copays

Priority Group	Definition
8	<ul style="list-style-type: none"> ▪ Veterans with gross household income above VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays <p>Veterans eligible for enrollment:</p> <p>Noncompensable 0% service-connected:</p> <ul style="list-style-type: none"> – Subpriority a: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority b: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less <p>Non-service-connected and:</p> <ul style="list-style-type: none"> – Subpriority c: Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status – Subpriority d: Enrolled on or after June 15, 2009, whose income exceeds the current VA or geographic income limits by 10% or less <p>Veterans not eligible for enrollment:</p> <p>Veterans not meeting the criteria above:</p> <ul style="list-style-type: none"> – Subpriority e: Noncompensable 0% service-connected (eligible for care of their service-connected condition only) – Subpriority g: Non service-connected

Analysis

Two decades have passed since Congress last reexamined VHA eligibility and benefits, and many far-reaching changes that affect veterans' health care have occurred in that time. In more than a decade of war, 2.75 million troops have deployed to Iraq and Afghanistan⁶³⁷ where many have faced long and repeated deployments; constant risk of injury and death; and high levels of psychological disorders, substance abuse issues, and physical health problems.⁶³⁸ Post-9/11-era veterans are enrolling for VA care at historically high levels.⁶³⁹

Under current law and VA policy, enrollment is open to a relatively broad spectrum of veterans, though some veterans with higher incomes are not eligible to enroll.⁶⁴⁰ As discussed above, the law draws distinctions between those whose health problems have been adjudicated as service-connected and those whose problems are deemed non-service-connected. If Congress substantially reduced funding for VA medical care, the distinction would be important because those with service-connected issues have higher priority for enrollment. Under VA's current enrollment policy, which bars only veterans with higher incomes from receiving care, the

⁶³⁷ Defense Manpower Data Center, *Contingency Tracking System (CTS) Deployment File*, (Dec. 31, 2015).

⁶³⁸ Institute of Medicine of the National Academies, *Returning Home from Iraq and Afghanistan: Readjustment Needs of Veterans, Service Members, and Their Families*, (Washington, DC: The National Academies Press, 2013), accessed June 25, 2016, <http://www.nationalacademies.org/hmd/Reports/2013/Returning-Home-from-Iraq-and-Afghanistan.aspx>.

⁶³⁹ Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, *Profile of Post-9/11 Veterans: 2014*, accessed May 27, 2016, http://www.va.gov/vetdata/docs/SpecialReports/Post_911_Veterans_Profile_2014.pdf.

⁶⁴⁰ Veterans Health Administration, *Enrollment Determinations*, VHA Handbook 1601A.03, 9-10 (2015). Veterans with gross household income that do not exceed VA's means test threshold and a geographic means test by more than 10 percent may enroll for care, while those with higher income and no other special eligibility may not.

COMMISSION ON CARE FINAL REPORT

statutory service-connected enrollment priority has little practical significance.⁶⁴¹ Future budget constraints could result in more restrictive enrollment criteria⁶⁴² or recurrence of lengthy wait times that hinder service-connected, disabled veterans' ability to receive timely care.

Current eligibility law does afford special status to veterans who deployed to a combat theater. It grants a 5-year window of eligibility for care to those veterans who are not otherwise eligible.⁶⁴³ All combat veterans are also eligible for readjustment counseling services at VHA Vet Centers without needing to enroll in VHA care and without time limitation.⁶⁴⁴ It is questionable, however, if the 5-year time limit takes sufficient account of continued reluctance of some veterans to seek care for behavioral health problems⁶⁴⁵ or of the difficulties of establishing service-connection years later for conditions that may be linked to wartime exposures to toxic substances.⁶⁴⁶ It is challenging for veterans to establish service-connection for health conditions that may have been caused by or associated with a long-distant exposure for which there may be no documentation. Given emerging evidence that combat exposure should be considered a risk factor for coronary heart disease,⁶⁴⁷ it has been suggested that combat exposure may not only take a toll on psychological health, but may exert a physiologic toll as well.⁶⁴⁸

Congress has attempted to remedy the challenge of documenting toxic exposures and establishing that particular illnesses are linked to wartime or other service exposure. It has, for example, enacted statutes that provide certain veterans eligibility for health care on the presumption that they were exposed to particular toxic substances.⁶⁴⁹ Congress went a step further in the Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 which provided eligibility for care for several types of cancer and other specified conditions for family members of veterans who had been exposed to drinking water contaminated with industrial solvents and other toxic chemicals at the Marine Corp base.⁶⁵⁰

Congress has made only limited provision for VA to cover care for family members of certain veterans,⁶⁵¹ but with research suggesting that long combat deployments can take a

⁶⁴¹ Prior to 1996, provisions of law required VA to ensure special priority to service-connected veterans in furnishing outpatient care. 38 U.S.C. § 1712(i), repealed by § 101(c), Pub. L. No. 104-262.

⁶⁴² Enrollment, 38 C.F.R. 17.36(c)(1).

⁶⁴³ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(3), as amended by Sec. 7, Pub. L. No. 114-2 (2015), accessed June 20, 2016, <https://www.govtrack.us/congress/bills/114/hr203/text>.

⁶⁴⁴ Readjustment Counseling Service, 38 U.S.C. § 7309.

⁶⁴⁵ American Public Health Association, "Removing Barriers to Mental Health Services for Veterans," accessed May 27, 2016, <http://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/14/51/removing-barriers-to-mental-health-services-for-veterans>.

⁶⁴⁶ Matthew S. King et al., "Constrictive Bronchiolitis in Soldiers Returning from Iraq and Afghanistan," *New England Journal of Medicine*, 365, no. 10 (2011): 222-230, accessed June 20, 2016, <http://doi.org/10.1056/NEJMoa1101388>.

⁶⁴⁷ Nancy F. Crum-Cianflone et. al., "Impact of Combat Deployment and Posttraumatic Stress Disorder on Newly Reported Coronary Heart Disease Among US Active Duty and Reserve Forces," *Circulation*, 129, (2014), accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.113.005407>.

⁶⁴⁸ Rachel Lampert, "Veterans of Combat: Still at Risk When the Battle is Over," *Circulation*, 129, (2014): 1797-1798, accessed June 20, 2016, <http://doi.org/10.1161/CIRCULATIONAHA.114.009286>.

⁶⁴⁹ Hospital, Nursing Home, Domiciliary, and Medical Care; General, 38 U.S.C. § 1710(e)(10).

⁶⁵⁰ Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012, Pub. L. No. 112-154, 126 Stat. 1165 (2012).

⁶⁵¹ Health Care of Persons Other Than Veterans, 38 U.S.C. §§ 1781-1787.

psychological toll on family members,⁶⁵² there may be circumstances under which it might be argued that VA should afford such family members behavioral health services. Studies indicate that longer deployments, deployment extensions, and posttraumatic stress disorder in military personnel are associated with psychological problems for the spouse.⁶⁵³ Long-term effects are unknown, yet studies suggest children may have heightened risk for psychosocial issues during a parent's deployment.⁶⁵⁴

The experience of the nation's longest war and increased options available under the Affordable Care Act (ACA), particularly to previously uninsured non-service-connected veterans, may raise new questions for policymakers.⁶⁵⁵ VHA's most recent survey of enrollees showed that 20 percent of enrollees reported that they were uninsured, down from 22 percent in 2014.⁶⁵⁶ Enrollment in VHA-provided care meets the ACA requirement for health care coverage, creating pressure to continue to provide care to those enrolled.⁶⁵⁷ Given that VHA serves large numbers who are poor or near poor and have chronic medical conditions and behavioral health problems,⁶⁵⁸ it is important to note that receiving care under an ACA plan would not necessarily be a substitute for the rich benefits afforded through VHA. In addition, adults in this population are only eligible for coverage under ACA through state expansion of Medicaid that 19 states have elected not to accept, making this option unavailable to poor or near poor veterans in many parts of the country.⁶⁵⁹

Over time Congress has expanded VA health care eligibility to increasingly more cohorts of non-service-connected veterans. There is wide variability among different cohorts in the extent to which veterans rely on VA care. Those at the higher-income levels (priority categories 7 and 8) who were generally not eligible for ambulatory care prior to 1996, for example, rely on VA for

⁶⁵² Robyn M. Highfill-McRoy et al., "Psychiatric Diagnoses and Punishment for Misconduct: The Effects of PTSD in Combat-Deployed Marines," *BMC Psychiatry*, 10, no. 1 (2010): 88, accessed June 20, 2016, <http://dx.doi.org/10.1186%2F1471-244X-10-88>. Swords to Plowshares, presentation to Commission on Care, January 21, 2016, <https://commissiononcare.sites.usa.gov/files/2016/03/Presentation-on-OTH-Discharges.pdf>. Note, in the interest of privacy the paper has used fictitious names to identify the former servicemembers. Swords to Plowshares, *Petition for Rulemaking to Amend 38 C.F.R. 3.12(d), 17.34, 17.36(d), Regulations Interpreting 38 U.S.C. § 101(2), Requirement for Service "Under Conditions Other Than Dishonorable"*, 42, 44, accessed May 26, 2016, <https://www.swords-to-plowshares.org/sites/default/files/VA%20Rulemaking%20Petition%20to%20amend%20regulations%20interpreting%2038%20USC%20101%282%292.pdf>.

⁶⁵³ H. Thomas De Burgh et al., "The Impact of Deployment to Iraq or Afghanistan on Partners and Wives of Military Personnel," *International Review of Psychiatry*, 23, no. 2 (2011): 192-200, <http://www.ncbi.nlm.nih.gov/pubmed/21521089>.

⁶⁵⁴ Gregory H. Gorman, Matilde Eide, and Elizabeth Hisle-Gorman, accessed June 20, 2016, "Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints," *Pediatrics*, 126, no. 6 (2010): 1058-1066, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-2856>. Anita Chandra et al., "Children on the Homefront: The Experience of Children from Military Families," *Pediatrics*, 125, no. 1 (2010): 16-25, accessed June 20, 2016, <http://doi.org/10.1542/peds.2009-1180>.

⁶⁵⁵ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁶ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁵⁷ "Affordable Care Act & Veterans," Department of Veterans Affairs, accessed May 27, 2016, <http://explore.va.gov/health-care-affordable-care-act?show=all>.

⁶⁵⁸ Kenneth W. Kizer, "Veterans and the Affordable Care Act," *Journal of the American Medical Association*, 307, no. 8 (2012): 789-790, accessed June 20, 2016, <http://doi.org/doi:10.1001/jama.2012.196>.

⁶⁵⁹ "The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update," Rachel Garfield and Anthony Damico, Kaiser Family Foundation, accessed March 29, 2016, <http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/>.

COMMISSION ON CARE FINAL REPORT

less than 22 percent of their outpatient care-needs, based on VA's most recent survey of veteran enrollees' health and use of care.⁶⁶⁰

One consideration, as suggested by a few Commissioners, is the feasibility of allowing veterans' family members and currently ineligible veterans to purchase VHA care through their health plans in areas where VHA hospitals and other facilities might otherwise need to close. In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. A related challenge is maintaining safe volume of care when patient loads decline. As an extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁶¹ Similarly, VHA may be unable to continue offer specialty care in certain areas if it forced to close facilities. Patients in a polytrauma unit for example, require a full spectrum of routine and nonroutine health care.

Closing a low-volume hospital may be the answer in some instances. But closing VHA facilities reduces the choices available to veterans. Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. See Appendix C for a further discussion of the challenge of future VHA hospital closures and an outline of suggested pilot programs.

Substantial changes have occurred since Congress last comprehensively examined eligibility for VHA care. These changes merit a reexamination of VA health care eligibility.⁶⁶² The Commission did not, however, view its charge of examining veterans' access and how best to organize VHA, locate health care resources, and deliver care in the years ahead⁶⁶³ as calling for it to make recommendations on this fundamental policy issue, and recommends that the President or Congress consider tasking another body to develop recommendations for VA care eligibility and benefit design. The Commission's work, however, has illuminated the fact that nothing in law or regulation assures a service-connected, disabled veteran of priority for care. VA can and should amend its regulations to provide for such priority, subject to a necessarily higher priority for urgent and emergent care.

Implementation

Legislative Changes

- Task another body to examine the need for changing eligibility for VA care and benefits design, which would include simplifying eligibility criteria, and may include exploring

⁶⁶⁰ Westat, *2015 Survey of Veteran Enrollees' Health and Use of Health Care*, 75, accessed May 27, 2016, http://www.va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁶⁶¹ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

⁶⁶² The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, 25, accessed April 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

⁶⁶³ Veterans Access, Choice, and Accountability Act of 2014, Pub. L. No. 113-146 (2014).

pilots for expanding eligibility for nonveterans to use underutilized providers and facilities when paid for through private insurance.

VA Administrative Changes

- SECVA should amend 38 C.F.R., chapter 17 to establish that veterans with service-connected disabilities shall be afforded priority for access to care, subject to the priority dictated by clinical care needs.

Other Departments and Agency Administrative Changes

- None required.

COMMISSION ON CARE FINAL REPORT

THIS PAGE INTENTIONALLY LEFT BLANK



APPENDIX A: FINANCING THE VISION AND MODEL

Estimating the Cost of Alternative Policy Proposals

This chapter presents estimates of the costs of allowing veterans access to expanded community care through integrated networks, as well as a range of other options. In the *Recommended Option*, the one chosen by the Commission and described in Recommendation #1, veterans would be eligible to receive community care for primary and standard specialty care with a referral from any primary care doctor in the VHA Care System. Special emphasis care, care provided in a distinctive fashion by VHA, is not included in community networks.

In addition to the *Recommended Option*, we considered three alternatives that are based on a similar concept of integrated networks, but which have potential costs that could vary dramatically due to differences in the openness of access to community care and the breadth of services eligible. We also estimated the costs of three options that differ in focus from the integrated network options, including options that move selected services entirely to the community, set up a premium support model, and expand access to all Priority 8 veterans. Finally, we estimated costs for two additional policies: expanding nurse navigator/care coordinator staff to help guide and coordinate veterans' care in the integrated networks of expanded community care and granting temporary eligibility for VA health care to those with other-than-honorable discharges.

Baseline Projections

We used projections from the Enrollee Health Care Projection Model (EHCPM) produced by VHA and Milliman as the baseline upon which to build our estimates. However, with the exception of the options involving premium support and an expansion of Priority 8 enrollment, we use separate analyses and not the EHCPM to derive the estimates. Costs of VA care are modeled as the product of utilization and cost per unit of care (unit cost). Utilization is dependent on both enrollment in, and reliance on, the VA health care system, total demand for health care, and other factors. Enrollment measures how many people enroll to receive VA health care, and reliance is the percentage of their medical care that enrollees receive through VA or VA-financed community care. Unit costs measure the cost of each health care service. Unit costs can be calculated for care in VA facilities, for care outside of VA facilities, or for both, depending on the scenario being estimated.

Utilization

Utilization depends on enrollment, reliance, total demand for health care, and characteristics of the health care system, such as medical technology and practice patterns. We discuss enrollment and reliance in further detail below, but overall demand for health care is similarly important. Enrollment, reliance, and overall demand each have a multiplicative effect on

COMMISSION ON CARE FINAL REPORT

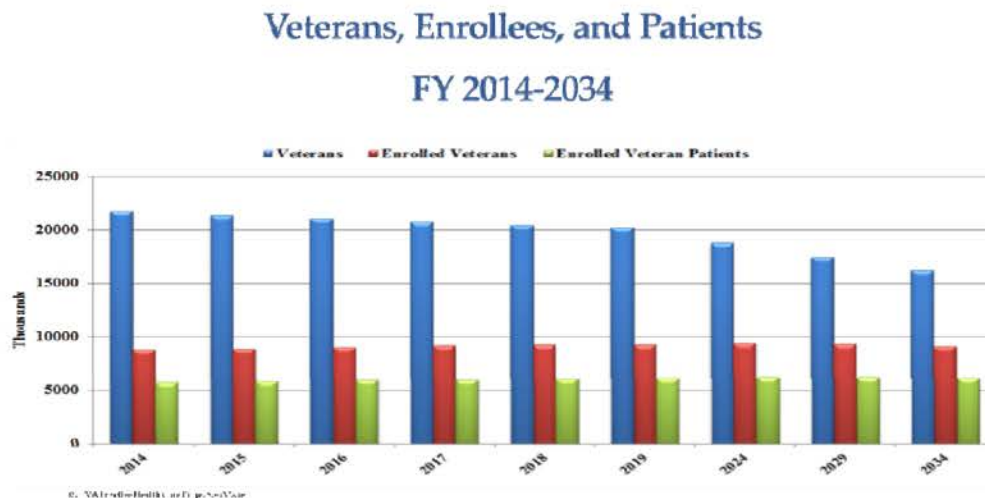
utilization and total costs. For example, if enrollment increases by 10 percent, costs will increase by 10 percent (assuming new enrollees have the same characteristics as existing enrollees). Thus, it is important to consider carefully the effect of any policy change on enrollment, reliance, and overall demand for health care. Each of these factors is subject to effects by policies that make care more convenient, less expensive, or less restricted.

Enrollment

Currently there are 22 million veterans, 9 million of whom have enrolled and 7 million of whom are eligible to enroll but have not done so. Even though the number of veterans is decreasing, projected numbers of enrollees and patients should remain relatively stable during the next 20 years. Younger veterans enroll at particularly high rates, and once enrolled, they remain continuously enrolled until death.

This enrollment trend is subject to change based on various inputs. Enrollment rates are projected based on current policy, and if policy changes, the number of enrollees and patients will change. For example, an increase in cost sharing would likely decrease enrollment and the number of patients, yet easing access to care would likely increase enrollment and the number of patients. Changes to other health insurance policies outside of VA can also affect enrollment and the number of patients (for example, changes to the Affordable Care Act).

Figure A-1. Changes in Number of Veterans, Enrollees over a 20-year Period



Reliance

On average, enrolled veterans receive 34 percent of their health care through VHA, and approximately 80 percent of enrollees have other health insurance in addition to VA health care. Many factors affect reliance rates including, age, income, service-connected disabilities, distance from VA facilities, cost-sharing levels, and characteristics of other insurance options. Any policy that affects the cost of receiving VA care, the convenience of receiving VA care, the cost or convenience of other health insurance held by enrollees, or demographic or health characteristics of enrollees, is likely to change reliance. Any increase in reliance will increase

costs to VHA, and the effect can be very large. In the absence of a policy change, VHA predicts that reliance will decline slightly from 34 percent to 32 percent during the next 20 years.

Unit Cost

Unit cost measures how much a particular service, procedure, or drug costs to provide. Unit costs can measure the cost of the unit of care in the VHA system or in the community, depending on where veterans receive care. We used unit cost projections from the EHCPM for 78 Health Care Service Categories (HSCs). The unit of measurement depends on the service. Examples include office visits, pathology procedures, vision exams, and inpatient surgical days. Unit cost projections reflect anticipated changes in price inflation and health care practice patterns, as well as historical trends. EHCPM projects separate unit costs, depending on whether veterans receive a service in a VA facility, in the community at historic Care in the Community (CITC) rates, or in the community at Medicare allowable rates. Any policy that affects the quantity of care provided in VA facilities, as opposed to the community, will have an effect on the total cost of care. If veterans receive care in the community, the rate of provider reimbursement will also affect costs.

Baseline Cost Projections

The baseline cost projections, produced by the EHCPM, show how cost will change in the future. They incorporate projected changes in enrollment, reliance, unit costs, and other factors. The projections reflect current policy with regard to enrollment eligibility and VA health care benefits, with the exception of the *Choice Program*, which is assumed to continue for veterans living more than 40 miles away from a VA medical care facility.⁶⁶⁴

We based the projections on assumptions about inflation and anticipated effects of changes in health care practice on the cost of VA health care in the next 20 years. New military conflicts, policies, legislation, regulations, and external factors, such as economic recession, can occur and change projected demand for VA health care during this period. The projections do not include requirements for several activities/programs not projected by the VA EHCPM, including nonrecurring maintenance; readjustment counseling; state-based, long-term services and support programs; and some components of the CHAMPVA program.

In the absence of any policy changes, costs increase from \$53 billion in 2014 to \$125 billion in 2032. This growth is largely due to inflation and how health care practices are expected to change over time, which reflects factors that affect the cost of both VA and non-VA health care. These trends increase the cost of VA health care regardless of changes in enrollment growth and demographics. Within enrollment, the increasing number of enrollees adjudicated for service-connected disabilities by the Veterans Benefit Administration (VBA) is the most significant driver of cost increases. Enrollees will likely increase their reliance to reflect the substantially higher reliance of enrollees in the service-connected Priorities 1-3.

These baseline estimates, along with our scenario estimates presented below, carry some key limitations. First, the EHCPM does not track capacity at VA facilities. We assume health care

⁶⁶⁴ Veterans qualifying based on wait times or excessive travel burdens are not included.

COMMISSION ON CARE FINAL REPORT

utilization will increase or decrease at the average unit cost, when in fact it is the marginal cost that would be relevant for cost estimates. This marginal cost could be smaller or larger than the average cost, depending on existing capacity. Although we did make some assumptions about fixed and variable unit costs when care leaves VA facilities in our policy estimates below, precise estimates are not possible given data availability. Second, the EHCPM does not consider health care capacity in local communities. For these and other reasons, the EHCPM is best for the near future and for policy scenarios that do not stray dramatically from current policy. A 2008 RAND review of the EHCPM highlighted these limitations, which are particularly important for analyzing policy changes such as expanded community care.⁶⁶⁵ In light of the types of policy choices VHA is likely to consider in the future, it would be particularly beneficial for VHA to collect and incorporate the data necessary to mitigate these limitations. Due both to these limitations and to the general uncertainty regarding any long-term changes in the health care system, we suggest focusing attention on the 2019 estimates of the scenarios below, as 2019 is the first year to incorporate the fully phased-in effects of the scenarios.

Policy Estimates

In this section, we present results for the *Recommended Option* and three alternative options for expanding access to providers outside of VA through integrated networks. These options expand community care for different categories of care and vary by whether referrals are required to receive specialty care. We present estimates for several other scenarios we examined, each with a design or focus that differs from the integrated network options. Finally, we estimate costs for two other policies discussed in this report: (1) expanding the use of nurse navigators to help patients coordinate their care in VA and in the community, and (2) expanding eligibility to all veterans with an other-than-honorable (OTH) discharge until the adjudication process is complete to determine whether they will remain eligible.

Community-Delivered Services Networks

This section describes the *Recommended Option* and the first three alternative options. At least initially, all care currently provided by VA would continue to be provided by VA. In addition, expanded community care, also called Community-Delivered Services (CDS), will be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA. CDS will focus on tertiary and quaternary care, and may include primary care and all standard specialty care, depending on the scenario considered. CDS will not include special-emphasis care and some types of specialty care provided in a distinctive fashion by VHA. The network of CDS providers that VA will coordinate varies by community. To make the flow of service both appropriate and smooth in operation, there will be navigators who will help guide veterans to the best and most appropriate providers inside and outside VA.

The Commission's recommendation to create the VHA Care System (see Recommendation 1) considers the ways in which health plans can vary the size and scope of networks as a means of managing costs. It highlights that broad, open networks offer greater choice, but narrow, well-

⁶⁶⁵ Katherine M. Harris, James P. Galasso, and Christine Eibner, "Review and Evaluation of the Enrollee Health Care Projection Model," RAND Corporation, Santa Monica, CA, 2008.

managed networks potentially result in lower costs. It discusses ways in which, after networks are designed, VHA could exercise additional cost controls by steering patients to different providers within the networks. Finally, the recommendation regarding the VHA Care System emphasizes that access and local needs are important considerations in setting up the integrated networks, and that governance of the networks should be a process of ongoing management and evaluation.

In the estimates that follow, we assume that networks are designed and governed in a way that gives major consideration to cost, choice, and access. We assume that management of the integrated networks would be an iterative process that involves continual evaluation of resulting outcomes, including cost outcomes, and that networks would be adjusted in light of those outcomes. We also assume that local communities and services with poor access would require more community providers and/or expanded capacity within VHA than those that already have adequate access. Finally, we assume that the networks will be integrated, relatively narrow, and well-managed with the aim of controlling costs effectively. One exception is that for the *Recommended Option*, we added an estimate that assumes less-managed, broader networks to illustrate that costs are sensitive to network size and management.

Technical Assumptions for Community-Delivered Services Options

We based our estimates on utilization and unit cost data and projections for 78 HSCs that we obtained from the VHA Office of Policy and Planning. Starting from a base year of 2014, we projected utilization and unit costs through 2034. For HSCs that are eligible for CDS networks, we assume a certain fraction of care, depending on the option, shifts from VA facilities to the networks. We assume traditional CITC will be offered and used at baseline levels.⁶⁶⁶ We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks. All effects are phased in during the first 5 years.

Both CDS networks and CITC are priced at Medicare allowable rates by matching Medicare fee schedule data to VA HSCs.⁶⁶⁷ A few benefits that are not covered by Medicare, such as dental, are priced at historic CITC unit costs. Cost sharing for CDS networks is assumed to be the same as that for care in VA facilities.

For care shifting into the CDS networks, we use data on the components of HSC unit costs that we obtained from the VA Allocation Resource Center. We assume VA is able to adjust resources such that only the equipment and national overhead portions of unit costs remain in VA facilities. These portions, which together averaged approximately 10 percent of care in 2014, form our proxy for the portion of unit costs that VA will not be able to shed in scenarios for which, on net, care leaves VA facilities for CDS networks. Note that unit costs do not include costs associated with the physical building or nonrecurring maintenance. These costs are not part of the EHCPM, and costs and/or savings associated with changes to facilities and nonrecurring maintenance are not included in our estimates.

⁶⁶⁶ CITC accounted for approximately 11 percent of modeled expenditures in the base year 2014.

⁶⁶⁷ Medicare Allowable rates were provided by Milliman at the request of VA. They were produced using repricing performed at the area-specific level for inpatient, outpatient, and professional care. For services that were not repriced within an HSC, Medicare amounts were estimated.

COMMISSION ON CARE FINAL REPORT

Improving access, choice, and/or quality of services is likely to induce greater reliance and enrollment in the VA system. Although reliance and enrollment increases result in greater budgetary costs for VA, it is important to note that these increases do not represent societal costs or costs to the government. The VA budgetary cost increases may be associated with reductions in out-of-pocket expenses and improved health care benefits for patients, as well as savings to Medicare, Medicaid, and other government programs. Our cost estimates are confined solely to the VA budget.

Approximately 52 percent of eligible veterans have enrolled in VA health care, and enrolled veterans receive 34 percent of health care through VA. There is little data from which to anticipate how reliance and enrollment might change under the scenarios, and our estimates use wide ranges of assumptions for these parameters. In forming our assumptions, we consider a variety of factors, such as insurance coverage and other characteristics of eligible veterans (both enrolled and unenrolled), survey responses of veterans (both enrolled and unenrolled) on use and reasons for lack of use of VA health care, and research on take-up of health insurance coverage.⁶⁶⁸ We are confident that enrollment and reliance would increase more with greater patient choice and access. For all options, we present low, middle, and high estimates.

In addition to increases in reliance and enrollment, reduced cost sharing, increased convenience of receiving community care, and the removal of a requirement to get a referral for specialty care can increase the total amount of medical care that a patient receives. Depending on the option considered, some health care is subject to reduced cost sharing from levels typical of private insurance coverage and Medicare to the very small levels of cost sharing found in the VA system. We assume utilization increases for health care subject to lower cost sharing and/or removal of a requirement to get a referral, with our estimates based in part on the literature examining how cost sharing affects health care demand.⁶⁶⁹

Caveats

There are a number of caveats associated with all of our estimates. These caveats are important, and to the extent that these assumptions do not hold, the estimates will be inaccurate. The estimates do not include savings and costs of reducing or repurposing infrastructure, or effects on VA's teaching, research, and emergency preparedness missions. Medicare allowable rates are assumed adequate to provide all veterans with robust CDS networks in their local areas. For care priced at historic CITC rates, national average rates are assumed to represent future rates. Shifting care into CDS networks does not affect the unit cost of care that remains in VA facilities. Reductions in the volume of care within VA facilities, and potentially adverse effects quality, are not addressed. Other than equipment and national overhead, the costs of care shifting out of VA facilities are phased out concurrently with other effects in the model. New enrollees are assumed to cost slightly less than existing enrollees for *CDS Alternative 3* and the

⁶⁶⁸ Examples of sources include: the 2014 American Community Survey; the 2010 National Survey of Veterans; the 2015 Survey of Veteran Enrollees' Health and Use of Health Care; Katherine Baicker, William J. Congdon and Sendhil Mullainathan, "Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics," *The Milbank Quarterly*, 90(1) (2012), 107-134.

⁶⁶⁹ Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals," Washington, DC, 2008. Willard G. Manning, Joseph P. Newhouse, Naihua Duan, Emmett B. Keeler, Arleen Leibowitz, and M. Susan Marquis, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review* 77(3) (1987), 251-77.

same as existing enrollees in the *Recommended Option* and *CDS Alternatives 1 and 2*.⁶⁷⁰ Finally, we do not estimate any administrative costs associated with CDS networks other than the additional RN care managers hired to handle the increased clinical and administrative burden of expanded community care. These additional, nonmodeled administrative costs could be substantial.

Commission Recommended Option

The *Recommended Option* would expand community care. At least initially, all care currently provided by VA would continue to be available through VA. In addition, expanded community care, also called CDS, would be provided by an integrated network consisting of providers (medical practitioners including physicians, midlevel practitioners and therapists, and hospitals and clinics) vetted by VA or a third-party administrator. The CDS network would include all primary and standard specialty care; it would not include special-emphasis care (care that is provided in VA in a distinct fashion).⁶⁷¹ In 2014, 68 percent of care would have been eligible for CDS networks at current VA prices. A referral from a primary care provider would be required to receive specialty care. This referral could come from a provider either at VHA or from the community network. In this scenario, we assumed all other characteristics of the VHA Care System would remain the same as under current policy. We assume that the *Choice Program* ends and that those formerly in the *Choice Program* will take advantage of the community care offered in the CDS networks.

We expect that allowing enrollees to get primary and standard specialty care in the community will increase reliance for care provided in the community because many veterans would have a choice among a larger number of providers and would be more likely to have the option to receive care at a more convenient location. We also expect enrollment to increase because some eligible veterans would be induced to enroll by the prospect of having VA pay for them to see a doctor in the community. We assume that 60 percent of eligible care shifts from VA facilities to CDS networks. Currently reliance is 34 percent. Under this scenario, we model reliance levels of 40, 50, and 60 percent, which correspond to reliance rates increases of approximately 18, 47, and 76 percent, respectively. These reliance increases apply only to CDS care, not CDS-eligible care that is provided in VA facilities. Although the choice of providers is expanded and wait times are potentially reduced in VA, there continues to be a requirement for a referral to access specialty care, as there is in the current system. We modeled enrollment increases of 5, 15, and 20 percent for the low, middle and high estimates, which assume integrated, narrow, and well-managed networks that are designed and managed with cost as one of the major considerations. We also modeled an enrollment increase of 50 percent, more consistent with a less-managed, relatively broad network for which cost is a less important consideration. Finally, we assume that newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks. Much of this care was

⁶⁷⁰ Assumptions based on previous analysis by VHA and Milliman.

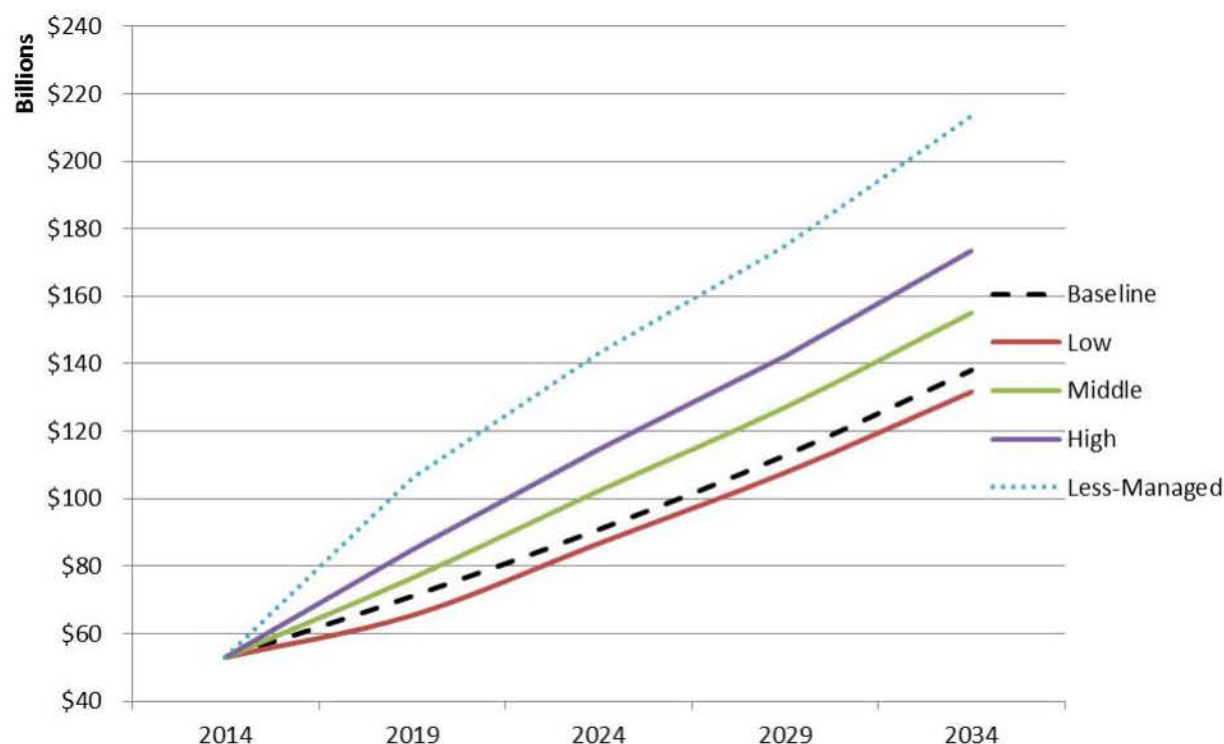
⁶⁷¹ Special-emphasis care includes: prosthetics and orthotics, recreational therapy, rehabilitative care, pharmacy, home-based primary care, spinal cord injury and disorders, some categories of long-term services and supports, mental health and homeless care. We count all mental health as special-emphasis because mental health categories cannot easily be differentiated by care that is VA special-emphasis and care that is not.

COMMISSION ON CARE FINAL REPORT

formerly subject to sizable cost sharing with private insurance or Medicare, and now it would be subject to little if any cost sharing associated with VA-financed care.

Figure A-2 displays estimates for the *Recommended Option*. Estimates for well-managed, narrow networks range from \$65 billion to \$85 billion in 2019, with a middle estimate of \$76 billion. The middle estimate is moderately above the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to the less costly Medicare allowable rates for CDS networks and CITC mitigate the increases. The estimate for the less-managed, broader network scenario is \$106 billion in 2019, illustrating that costs could increase markedly if governance of the network places less importance on cost or if VA were unsuccessful in tightly managing the network.

Figure A-2. Projected Costs of Recommended Option



APPENDIX A
FINANCING THE VISION AND MODEL

COST ESTIMATES Commission on Care Scenarios							
	Brief Description	Utilization Increase	Enrollment Increase (low, middle, high)	Reliance (low, middle, high)	Cost FY 2014 Actual (billions)	Cost FY 2019 Projected (billions)	Cost FY 2034 Projected (billions)
Baseline	2014 Actual		9,078,615	34%	\$53	\$ 71	\$ 138
	Referral Based Care in VHCS (68% of current VHA care eligible as CDS)	+20% of new demand in CDS Care	5%	40%		\$ 65	\$ 132
Recommended (low)	same	same	15%	50%		\$ 76	\$ 155
Recommended (middle)	same	same	20%	60%		\$ 85	\$ 173
Recommended (high)	same	same	50%	60%		\$ 106	\$ 213
	Similar to Recommended but primary care, inpatient med and surg and some standard specialty care not eligible for CDS remain in VHA (47% of care eligible for CDS)	+20% of new demand in CDS Care	0%	10%		\$ 66	\$ 128
Alternative 1 (low)	same	same	5%	35%		\$ 73	\$ 140
Alternative 1 (middle)	same	same	10%	50%		\$ 78	\$ 151
	Similar to Alternative 1 but primary care coordinator must only be consulted; no referral required (47% of care eligible for CDS)	+20% CDS eligible Care	5%	60%		\$ 97	\$ 191
Alternative 2 (low)	same	same	10%	80%		\$ 123	\$ 243
Alternative 2 (middle)	same	same	20%	100%		\$ 154	\$ 307
	Similar to Alternative 2 but primary care, inpatient med/surg and specialty care eligible for CDS and no consult required	+20% CDS eligible Care	75% (level)	80%		\$ 167	\$ 320
Alternative 3 (low)	same	same	85% (level)	90%		\$ 206	\$ 395
Alternative 3 (middle)	same	same	95% (level)	100%		\$ 250	\$ 479
	Move most standard ambulatory specialty care to community	+20% of new demand in CDS Care	0%	10%		\$ 64	\$ 128
Keep Selected Services (low)	same	same	4%	25%		\$ 70	\$ 136
Keep Selected Services (middle)	same	same	8%	40%		\$ 75	\$ 145
Keep Selected Services (high)							
	Enrollees under age 65 can choose a subsidized insurance premium with cost sharing in lieu of VHA care	42% of enrollees <65 choose premium support	6%			\$ 82	\$ 158
Premium Support							
	Allow all eligible veterans to enroll	increase to 30% market share among priority 8	5%			\$ 72	\$ 140
Eligibility Expansion							
Initiatives	Nurse navigators for CDS care					\$ 71	\$ 138
	Make veterans with Other than Honorable Discharges Temporarily Eligible for VA Health Care While Claims are Adjudicated					\$ 72	\$ 139

Additional Sample Cost Models

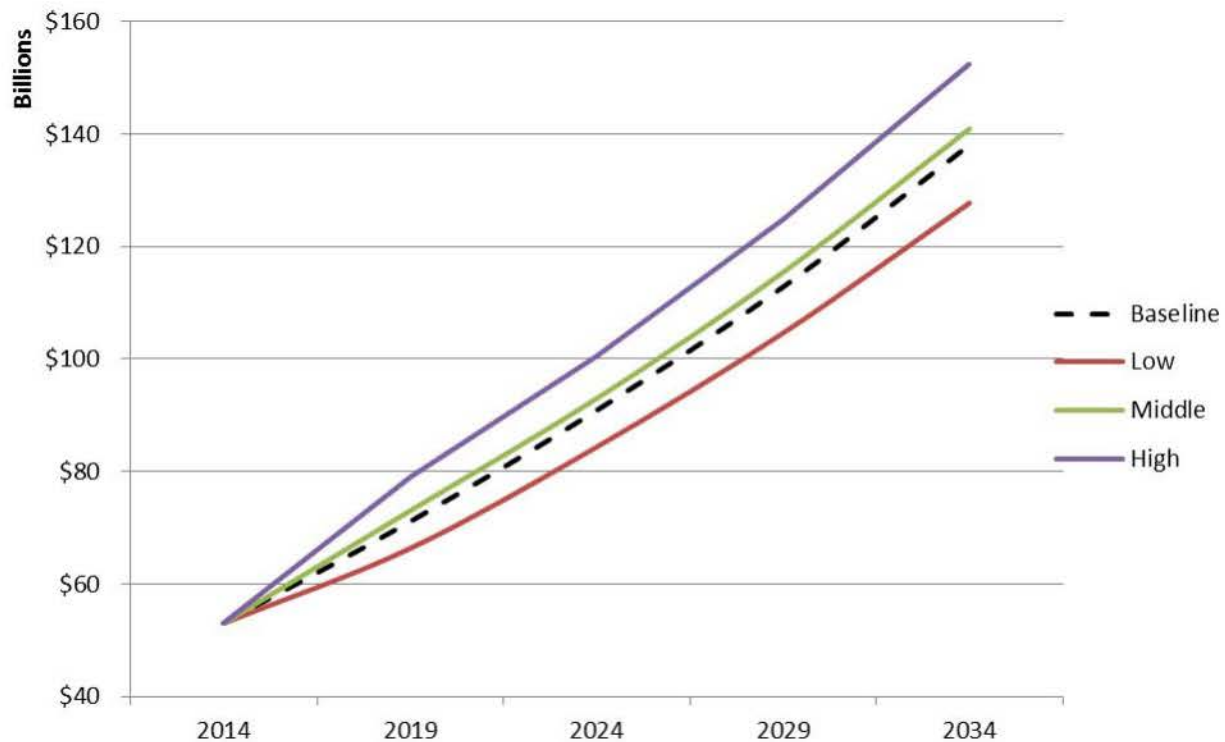
CDS Alternative 1

CDS Alternative 1 is similar to the Commission's *Recommended Option* above. The main difference is that a narrower subset of services is available in the CDS networks. Primary care, inpatient medical and surgical care, and some standard specialty care are not eligible for CDS networks and must be accessed within VA. The CDS network for *CDS Alternative 1* would focus on tertiary and quaternary care; it would not include primary care, some specialty care, inpatient medical and surgical care, and special-emphasis care (care that is provided in VA in a distinct fashion). In 2014, 47 percent of care would have been eligible for CDS networks.

Because less care is eligible for CDS networks than in the *Recommended Option*, less care will shift to CDS networks, reliance increases will be smaller, and enrollment increases will be smaller. We assumed that 50 percent of eligible care shifts from VA facilities to CDS networks. We modeled increases in reliance of 10, 35, and 50 percent, which correspond to reliance rates of approximately 37, 46, and 51 percent. These reliance increases pertain only to CDS care, not CDS-eligible care provided in VA facilities. We modeled enrollment increases of 0, 5, and 10 percent. As in the *Recommended Option*, we assume newly entering veterans who receive treatment in CDS networks because of this policy have a 20 percent utilization increase for new demand in CDS networks.

Figure A-3 displays estimates for CDS Alternative 1. Estimates range from \$66 billion to \$78 billion in 2019, with a middle estimate of \$73 billion. As in the *Recommended Option*, the middle estimate is close to the baseline projection of \$71 billion. Although reliance and enrollment increases push VA budgetary costs up, the switch from VA unit costs to Medicare allowable rates for CDS networks and CITC offsets these effects.

Figure A-3. Projected Costs of CDS Alternative 1



CDS Alternative 2

Like *CDS Alternative 1*, CDS care in *Alternative 2* would focus on tertiary and quaternary care. CDS networks would not include primary care, special-emphasis care, inpatient medical and surgical care, and some types of specialty care.

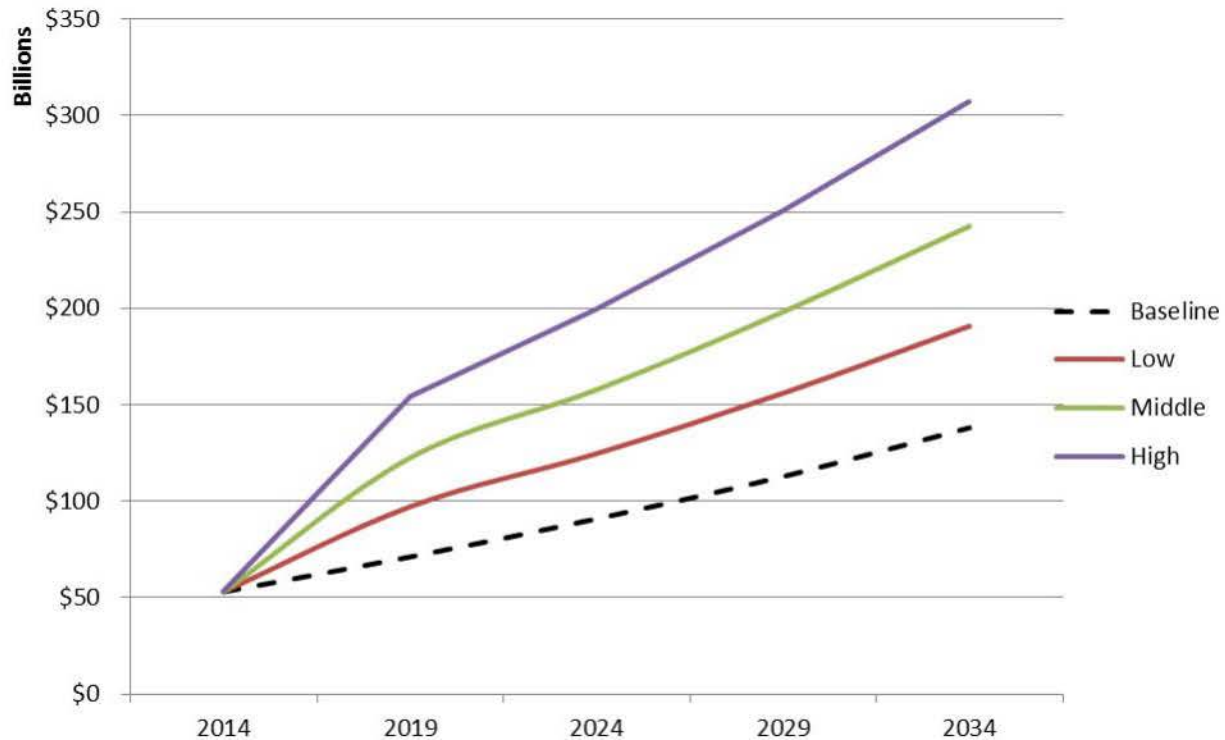
This option differs from the *Recommended Option* and *CDS Alternative 1* in that veterans must consult their VHA primary care provider in some way before seeking specialty care, but they *do not* need a referral to receive CDS eligible care whether they receive it in or out of VA. Some specialty care, all primary care, and all special-emphasis care are only provided in VA unless the veteran is eligible for traditional CITC. However, after the primary care consultation, the choice of whether to seek eligible care in CDS networks is entirely up to the veteran. As in *CDS Alternative 2*, the care eligible for CDS networks comprised 47 percent of total modeled expenditures in 2014.

We expect reliance increases to be relatively high, and we apply these reliance increases to CDS eligible care regardless of where veterans receive it because referrals are not required for any CDS eligible care. Further, we expect enrollment increases to be higher than the *Recommended Option* and *CDS Alternative 1* because the absence of a referral requirement makes this a more attractive policy for potential enrollees. We model reliance rates of 60, 80, and 100 percent for care eligible for CDS networks; enrollment increases of 5, 10, and 20 percent; 70 percent of VA facility care shifting into CDS networks; and a 20 percent utilization increase for CDS eligible care.

COMMISSION ON CARE FINAL REPORT

Estimates are displayed in Figure A-4. In 2019, the baseline projection is \$71 billion. *CDS Alternative 2* estimates range from \$97 billion to \$154 billion, with a middle estimate of \$123 billion. The potential for considerable reliance and enrollment increases could push costs substantially higher than the baseline.

Figure A-4. Projected Costs of CDS Alternative 2



CDS Alternative 3

CDS Alternative 3 differs from *Alternative 2* in two main ways. First, a broader array of care is eligible for CDS networks. CDS would include primary and standard specialty care, including inpatient medical and surgical care. It would not include special-emphasis care (care that is provided in VA in a distinct fashion). This array of eligible care is the same as that for the *Recommended Option*, and comprised 68 percent of total modeled expenditures in 2014. Second, enrollees do not need to consult with a primary care doctor in order to access CDS eligible care.

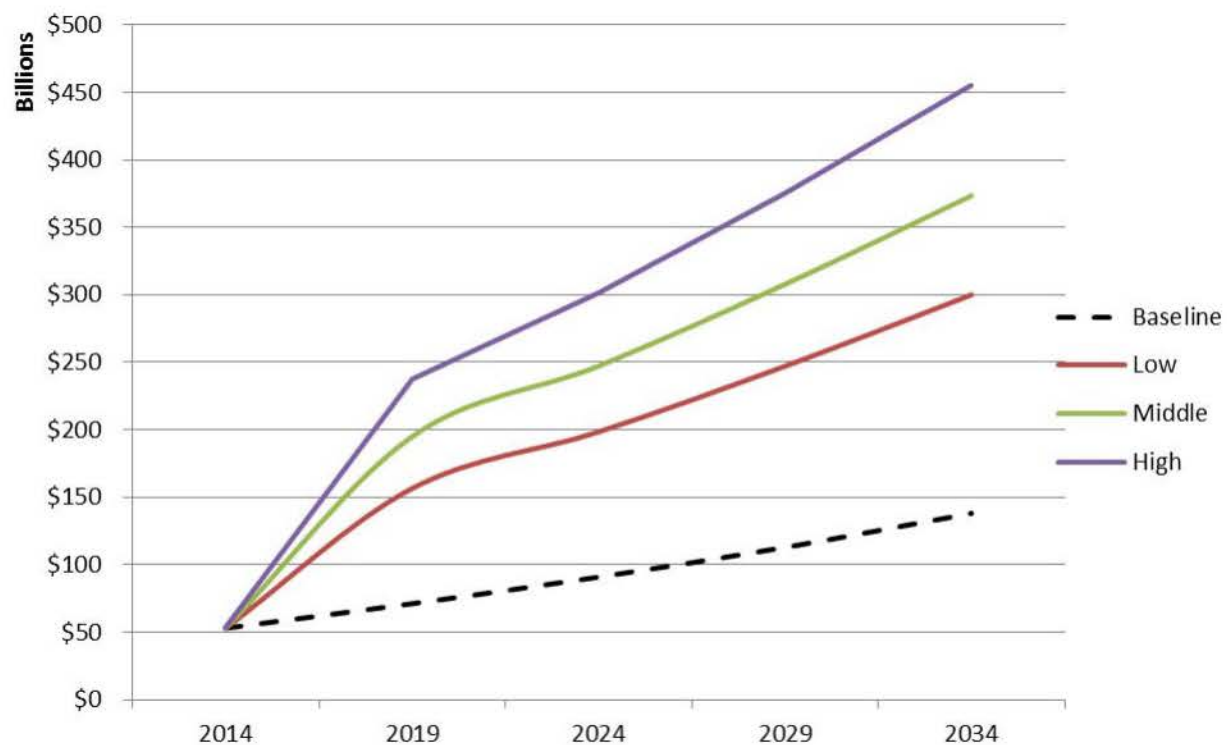
CDS Alternative 3 would offer an extremely generous benefits package for patients. With no referral or consultation, no premiums, and little if any copayments, patients would have access to a robust network of high-quality providers in their area. Although care within VA facilities would be available, no clinical contact would be necessary for those seeking care in CDS networks. Even within VA facilities, care is more attractive because patients would no longer need to consult their primary care doctors to receive specialty care. The benefits of this option contrast with the 10 to 30 percent cost sharing typical in Medicare and private coverage, the low

provider reimbursements, stigma and access barriers often associated with Medicaid,⁶⁷² and the requirements for referrals and/or prior authorizations that are widespread among health insurance plans. Few veterans would have reason to turn down such an attractive option.

Consequently, we model high ranges for reliance, enrollment, and care shifting into CDS networks. We model reliance rates of 80, 90, and 100 percent for all CDS eligible care; enrollment shares of 75, 85, and 95 percent; and a 70-percent rate of eligible care shifting from VA facilities to CDS networks. We apply the reliance increases to all care eligible for CDS networks, even if the care is provided in VA facilities or traditional CITC, because this option eliminates the need for consultations with primary care doctors for all CDS eligible care. Additionally, we assume that the total amount of CDS eligible care received by veterans from any provider and payer increases by 20 percent due to the lack of a referral requirement and/or reduced cost sharing.

Estimates are displayed in Figure A-5. In 2019, when effects are fully phased-in, estimated costs range from \$156 billion to \$237 billion, with a middle estimate of \$195 billion. This compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that this option could result in very large cost increases relative to the baseline scenario, *Recommended Option*, and *CDS Alternatives 1 and 2*.

Figure A-5. Projected Costs of CDS Alternative 3



⁶⁷² Yu-Chu Shen and Stephen Zuckerman, "The Effect of Medicaid Payment Generosity on Access and Use among Beneficiaries," *Health Services Research* 40, no. 3 (2005), 723-44. Jennifer Stuber and Karl Kronebusch, "Stigma and Other Determinants of Participation in TANF and Medicaid," *Journal of Policy Analysis and Management* 23, no. 3 (2004), 509-530.

COMMISSION ON CARE FINAL REPORT

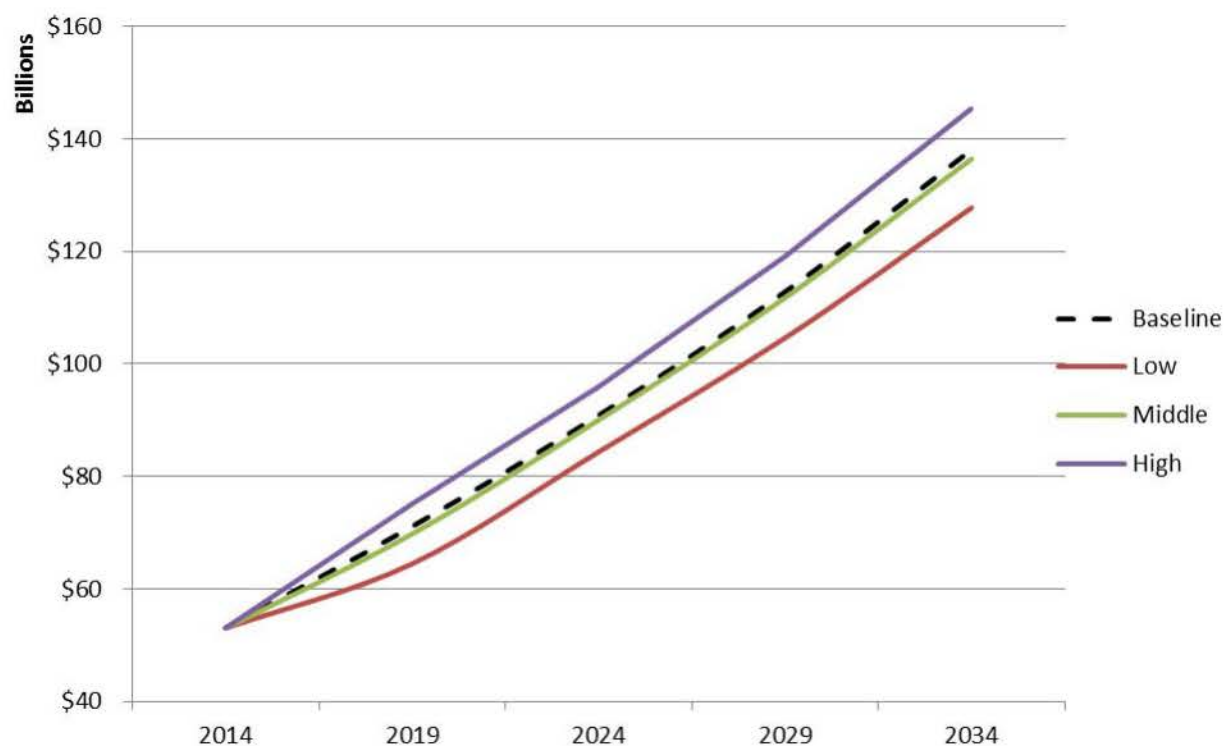
Keep Selected Services

The *Keep Selected Services (KSS)* scenario would move most standard ambulatory specialty care entirely into the community, yet keep the remainder of care entirely within VA facilities or traditional CITC. Although VA would no longer provide most standard ambulatory specialty care in VA facilities, it would continue to provide primary care, inpatient care, and special-emphasis care in VA facilities, including long term services and supports, prosthetics and orthotics services, inpatient and outpatient mental health and substance abuse, inpatient medical and surgical care, prescription drugs, medication management, recreational therapy, and immunizations. Under this scenario, approximately 35 percent of the cost of care currently provided in VA would be provided solely in the community. Providers in the community would receive Medicare rates.

We modeled increases in reliance of 10, 25, and 40 percent, which correspond to reliance rates of approximately 37, 43, and 48 percent. These reliance increases pertain only to care that moves into the community. We modeled enrollment increases of 0, 4, and 8 percent.

Estimates are displayed in Figure A-6. In 2019, when effects are fully phased-in, estimated costs range from \$64 billion to \$75 billion, with a middle estimate of \$70 billion. This estimate compares to a baseline projection of \$71 billion. Although estimates are highly uncertain, a key takeaway is that even with expanded community care, cost increases are constrained when veterans cannot choose whether they receive care in VA facilities or in the community.

Figure A-6. Projected Costs of Keep Selected Services Scenario



Premium Support⁶⁷³

Under the *Premium Support* (PS) scenario, all current and future enrollees younger than age 65 can choose a subsidized insurance premium with cost sharing (for some priorities) in lieu of their current VHA benefit. Enrollees electing the premium and cost sharing subsidy no longer have access to any VA services, including the special services VA offers. Under this scenario, there is an annual election period, and VA actively engages with enrollees to make a decision. Enrollees ages 65 and older receive no additional benefit options.

For those enrollees choosing the subsidized insurance program, the cost sharing varies by priority level: 10 percent for priorities 1 and 2; 20 percent for priorities 3 and 4; 30 percent for priorities 5 and 6; and 40 percent for priorities 7 and 8. Veterans would buy *Silver* policies on the state individual insurance exchanges, and VA would provide additional cost sharing assistance to meet the target subsidy. If enrollees purchased plans offered with lower cost sharing, such as *Gold* (20 percent cost sharing) or *Platinum* plans (10 percent cost sharing), the additional premium costs would likely exceed the cost of purchasing a Silver plan and subsidizing the cost sharing. The cost estimates did not consider the potential effect of adding a large number of veterans on exchange plans. Were VA to do this, considerations for veteran morbidity as well as the proposed cost sharing subsidies would need to be accounted for within the purchase of state exchange plans from commercial insurers.

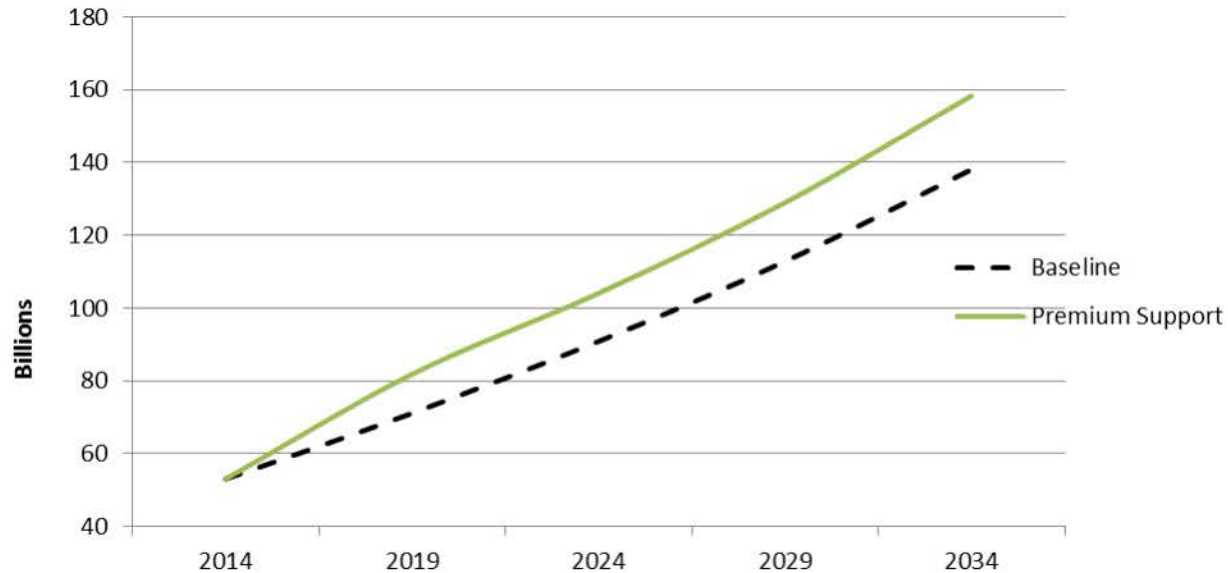
To determine participation rates in the subsidized premium program, we summarized enrollees' FY 2014 baseline data into cost brackets by attaching 2015 EHCPM unit costs to workload and then summarizing the total cost of workload provided to each enrollee. Overall, 42 percent of enrollees younger than age 65 were assumed to select the subsidized premium option, but the model assigned different rates of participation depending on enrollees' priority level and historical VA utilization. Enrollees with little to no costs were assumed to participate in the program at a higher rate as compared to those who had larger levels of VA costs. Participation rates for priority 5 veterans were assumed to be half the rates set for other priority levels. This assumption was made because many of these lower-income enrollees already have the option of participating in a highly subsidized state exchange plan with low cost sharing. It is also assumed that offering this option will motivate additional nonenrolled veterans to enroll to receive the subsidized premium plan. To estimate this effect, we analyzed the proportion of veterans by priority level with either no insurance or individual insurance plans, as reported in recent years of data captured by the American Community Survey (ACS). We estimated that this potential subsidy would lead to an additional 577,000 enrollees over the projection period.

Finally, it is assumed that the subsidized premium plan serves as a primary payer and does not supplement other coverage available to the enrollee, such as Medicare or employer sponsored insurance.

⁶⁷³ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

COMMISSION ON CARE FINAL REPORT

Figure A-7. Projected Costs of Premium Support Scenario



Eligibility Expansion⁶⁷⁴

Under the *Eligibility Expansion* (EE) scenario, the VA health care system expands to allow all veterans to enroll in VA health care. In 2014, half of veterans eligible under priorities 1-7, 8b,⁶⁷⁵ and 8d were enrolled, representing a 50 percent *market share*,⁶⁷⁶ with the highest market share among those with service-connected priorities. The market share among Priorities 8a and 8c was an estimated 21 percent, reflecting enrollment from before suspension began in January 2003 and from enrollees who initially enrolled in another priority and later transitioned to Priorities 8a and 8c. If the suspension of new priority 8 enrollment had never occurred, we estimate that the market share would be 28 percent in 2014 and 30 percent in 2021 under natural growth and priority transition rates.

Under a scenario of lifting priority 8 enrollment suspension beginning in FY 2017, we estimate that the market share would climb steadily during a 5-year phase-in period to reach 30 percent in 2021, which equates to 464,000 new priority 8 enrollees. The market share is not expected to reach the level observed among other priorities because Priority 8 veterans have higher incomes, are not service-connected disabled, are more likely to have employer-sponsored coverage and individually purchased health plans, and are less likely to be uninsured relative to other priorities. Further, regression analysis of market shares among veterans in census data demonstrated that higher income veterans, nondisabled veterans and veterans with employer-sponsored health insurance are all less likely to enroll. To develop the cost estimates, newly

⁶⁷⁴ Analysis developed by Milliman for VHA Office of the Assistant Deputy Undersecretary for Health (ADUSH) for Policy and Planning.

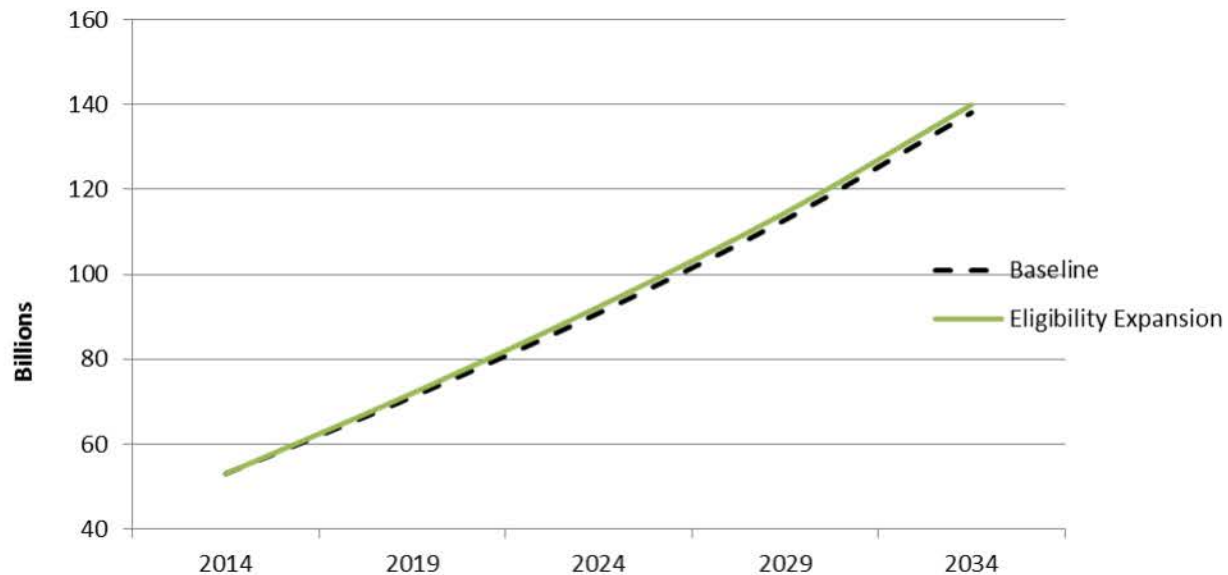
⁶⁷⁵ Priority 8b and 8d were enrolled on or after June 15, 2009 and have incomes that exceed the current VA or geographic income limits by 10 percent or less.

⁶⁷⁶ Market share is the percentage of veterans who are enrolled in VHA out of all veterans. This differs from the enrollment share, which is the percentage of eligible enrollees who are enrolled.

eligible priority 8 veterans are assumed to have the same morbidity and reliance as current priority 8 enrollees.

By 2032, based on the estimated market share, we project an additional 368,000 priority 8 enrollees with an additional \$1.8 billion in costs.

Figure A-8. Projected Costs of Eligibility Expansion Scenario



Additional Cost Factors

Nurse Navigators

VHA already has a robust care manager program that largely overlaps with the proposed nurse navigators in the CDS scenarios. VHA patient aligned care teams (PACTs) were created to coordinate care and maintain long-term relationships with patients. Most PACTs exist in a primary care setting, but there are also special-emphasis PACTs, such as those for spinal cord injury and disorders, geriatrics, and HIV care. All patients may choose to be assigned to a primary care PACT, and the vast majority do so: There are approximately 5.3 million unique patients in primary care PACTs out of a total of 5.8 million.

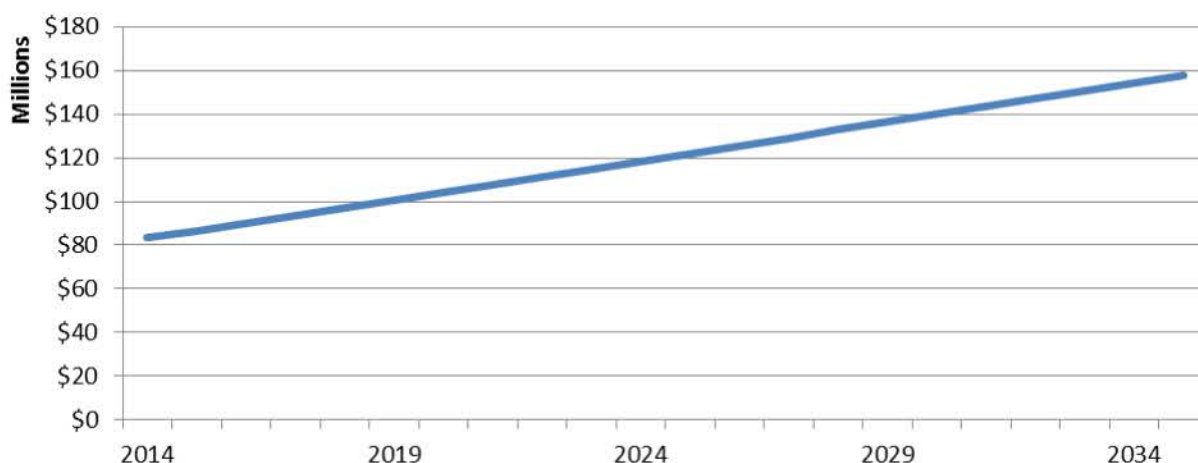
The primary care PACT typically consists of a provider, an RN care manager, a clinical associate, and a clerk. This team is assigned to a panel of approximately 1,200 patients. There are also expanded team members who are assigned to multiple panels, such as clinical pharmacy specialists, nutritionists, and behavioral health professionals. The RN care manager is the lynchpin of the primary care PACT.

One of the tasks of the care manager is to coordinate care received in VHA facilities with care received in the community. Because this coordination role would increase with the CDS scenarios, we provide a notional estimate for expanding the number of care managers to account for the additional administrative and clinical burden of an increase in community care.

COMMISSION ON CARE FINAL REPORT

Based on discussions with VHA primary care operations and policy staff, we assume that one additional RN care manager per five panels would be necessary to handle a substantial increase in community care such as that associated with the CDS scenarios.⁶⁷⁷ Based on 2014 data on the number of patients in PACTs and the recommended panel size, we estimate that 882 RN care managers would need to be hired if the CDS scenarios were fully phased in. Incorporating the average total compensation of RN care managers (\$94.4 thousand in FY 2014) and inflating costs using the projected patient population and personnel inflation trend from the EHCPM, we generate the following cost estimates. These estimates are assumed to be fully phased in. The cost of this policy is \$100 million in 2019 and rises to \$158 million in 2034.

Figure A-9. Cost of Hiring Additional RN Care Managers



Other-than-Honorable Discharges

We also consider a policy for which those with an OTH discharge are made temporarily eligible for VA health care while their claims are adjudicated. The adjudication process would determine whether these individuals would remain eligible for care or would lose eligibility. Adjudication would be based on the reason for the discharge. For example, if the discharge were due to behavior associated with a mental health condition caused by serving in the military, that person would likely be positively adjudicated. However, the specific criteria for adjudicating cases still needs to be determined.

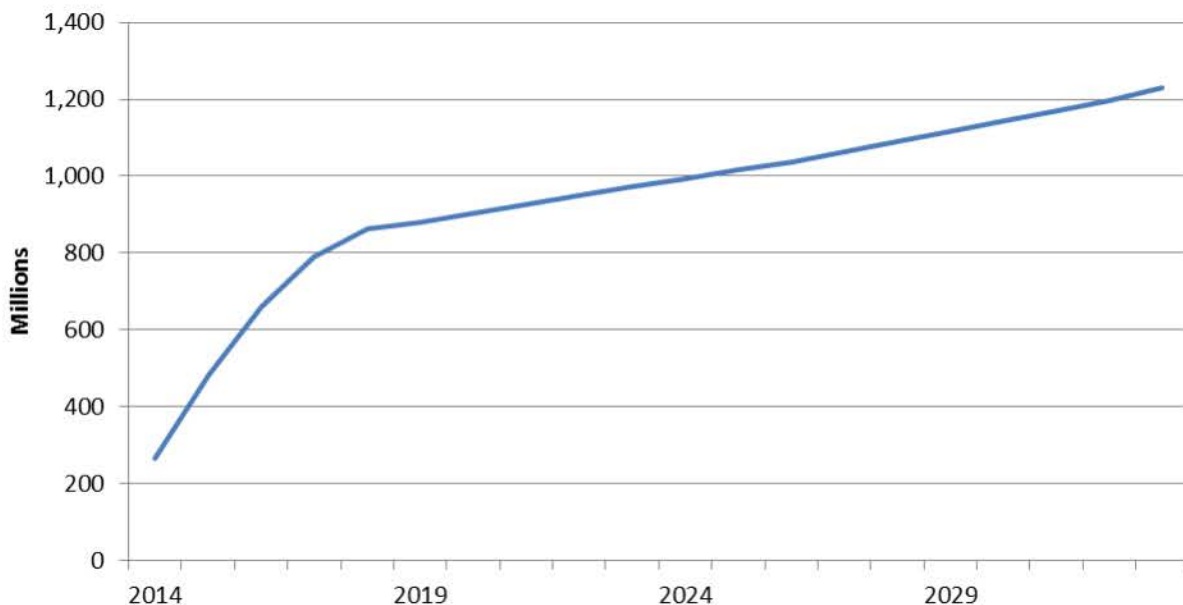
To model the cost of this proposal, we assume all people with an OTH discharge who would otherwise be eligible for VHA care are initially eligible. We assume that, consistent with the rest of the population, 73 percent of veterans with an OTH discharge are eligible for VA health care based on income and disability criteria. During a period of 5 years, their cases are examined, and 50 percent are positively adjudicated. Whether this number is actually higher or lower than 50 percent will depend on the exact details of the policy as well as the specific circumstances of veterans with an OTH discharge. In our model, the number of eligible veterans with an OTH discharge who enroll increases during the first 5 years as they become aware of the new rules. It

⁶⁷⁷ These estimates would differ depending on the CDS option pursued, but we provide a single notional estimate to give a sense of the magnitude of costs involved.

increases to 52 percent, which is the enrollment share of veterans who are currently eligible. In reality, this rate could be higher or lower for those with an OTH discharge if they are different from those who are already eligible. We assume costs per patient are similar to other veterans of the same age.

The cost of this policy increases from \$264 million in 2014 to \$1.23 billion in 2033. Fully phased-in, the cost is \$864 million in 2019. The shape of the cost curve reflects increasing enrollment during the first 5 years as veterans learn about the new rule and sign up. It also reflects adjudications as all enrolled veterans are initially eligible and then their eligibility is adjudicated during the 5 years. These calculations reflect estimates that the number of veterans with an OTH discharge for active duty military has fallen from a high of 8.8 percent in 2002 to 2.1 percent in 2015. We assume that the rate continues at 2.1 percent of discharges throughout the projection window.

Figure A-10. Projected Costs of Temporarily Covering Veterans with OTH Discharges



Conclusion

The estimated cost of allowing veterans to receive expanded community care through integrated networks varies dramatically depending on the specifics of the policy, including which categories of care are eligible for the community and whether referrals are required to access specialty care. We estimate that the *Recommended Option*, which provides increased community care that is reimbursed at Medicare allowable rates but maintains referrals for specialty care, increases costs modestly, assuming that networks are narrow and well-managed with cost as a major consideration. *CDS Alternative 1*, which offers a more restricted array of services eligible for CDS care, yet maintains a referral requirement, does not substantially increase costs. However, *CDS Alternative 3* and to a lesser degree *Alternative 2*, which eliminate the need for referrals for standard specialty care, potentially lead to very high costs. The estimated costs of the other scenarios range from small to substantial, though these costs would

COMMISSION ON CARE FINAL REPORT

ultimately depend on the details of the proposals (e.g., the premium support schedule). Finally, we find that the costs of introducing expanded nurse navigators/care coordinators and making those with OTH discharge temporarily eligible are comparatively modest.

APPENDIX B:

LEADERSHIP IMPLEMENTATION

Table B-1. Organizational Health and Cultural Transformation

Action	Responsible	Timeline
That VHA create a comprehensive, coordinated, sustainable cultural transformation effort by aligning programs and activities around a single, benchmarked concept.		
Establish the charter for the cross-functional SE team responsible for cultural transformation.	SECVA/DEPSECVA or CVCS depending on level	Now (0-6 mos)
Assess cultural transformation models and decide on a single model.	Chartered SE team	Now (0-6 mos)
Create an execution strategy for cultural transformation.	Chartered SE team	Now (0-6 mos)
Develop communication strategy and materials and release.	Chartered SE team	Near (18 mos)
That VHA aligns leaders at all levels in support of the cultural transformation strategy.		
Establish a subcommittee under the SE team to drive leadership transformation.	Chartered SE team	Near (6 mos)
Establish leadership standards for behaviors and actions.	Chartered SE team Subcommittee	Near (6-9 mos)
Publicize the standard.	Chartered SE team Subcommittee/CVCS/HTM	Near (12 mos)
Develop assessment tools.	SE Subcommittee/NCOD, NCEHC, HTM	Near (12-24 mos)
Establish expectations (in policy) for use of leadership standards in IDPs, performance review, hiring, promotions.	HTM/CVCS	Near (12-36 mos)
Provide coaching to the standard.	(Current HCM office responsible)	Near (24 mos)
Collect standards, training, support materials into a living curriculum for leaders.	EES/HTM	Near (24 mos)
Modify VA Directive 5021 (Employee/Management Relations) to include unacceptable behavior and unacceptable performance standards related to organizational transformation responsibilities of leaders and update table of penalties to correspond.	HRA/HTM	Future (36 mos)
That VHA align frontline staff in support of the cultural transformation strategy.		
Establish subcommittee to support staff transformation.	Chartered SE team	Near (9 mos)
Establish behavioral expectations/requirements for staff.	Subcommittee	Near (9-18 mos)
Develop hiring tools against the staff standard.	Subcommittee	Near (18-36 mos)
Establish requirements (in policy) for use of the standard for IDP, performance reviews, advancement in grade/promotions.	HTM/HRA/nursing and similar/unions	Near (18-36 mos)

COMMISSION ON CARE FINAL REPORT

Action	Responsible	Timeline
Support leaders and supervisors at all levels of the organization to communicate and reinforce these standards with staff (see align leaders, above).	(Policy owner)	Near (18 mos)
Establish program office and VAMC standards and strategy for execution.		
Establish subcommittee to develop VAMC and PO execution standards.	Chartered SE team	Near (18 mos)
Establish execution strategy and policy requirements.	Chartered SE team Subcommittee/NCEHC/ NCOD	Near (18-36 mos)
Develop consolidated, meaningful metrics with input from experts and field users.		
Assign responsibility for metric development.	Chartered SE team/CVCS	Near (6 mos)
Develop and test metrics.	Organizational Excellence	Near (6-18 mos)
Deploy metrics.	Chartered SE team/CVCS/ (policy owner)	Near (18 mos)
Identify outliers and intervene.	SE team/CVCS/(policy owner)	Near (24 mos)

Table B-2. Recruitment, Retention, Development, and Advancement

Action	Responsible	Timeline
VHA executives are required to make the leadership system a top priority for funding, strategic planning, and investment of their own time and attention.		
Establish a VHA leadership management goal for inclusion in the 2018 budget with specific targets, including diversity targets.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (3 mos)
Submit the leadership management goal to VA for inclusion in the budget submission for 2018.	VHA OPP and CVCS	Now (3 mos)
Adopt VHA leadership management goal and submit to OMB/White House.	VA OPP and SECVA	Now (3 mos)
Establish an operational plan and accountability mechanisms for meeting these goals.	VHA Human Capital Management/NLC leadership subcommittee of the HR committee	Now (4 mos)
Include yearly targets in the performance plan of the CVCS and SES members.	VHA NLC subcommittee on performance planning	Now (4 mos)
Schedule regular communication (at least quarterly) to the field that speaks to mission, vision, values, and expectations for ethical behavior.	CVCS	Now – ongoing
Schedule regular meetings with VHACO and field senior staff that allows for a discussion of mission, vision, values and expectations for ethical behavior.	CVCS	Now – ongoing
Develop opportunities for developing leaders to participate in the leadership and management decisions and processes of VHA.	CVCS /ask NLC executive committee to develop and implement a plan	Now (6 mos)
Adopt and implement a comprehensive system for leadership development and management.		
Convene a group to review ACHE and the National Center for Health Care Executives and devise a benchmarked model that meets the needs of health care executives in VHA as well as the private sector.	NCEHC with NCOD, & Human Capital Management; report to the NLC subcommittee for leadership development	Now (6 mos)
Create career tracks for key positions based on this new competency model.	HTM	Near (within 12 mos)
Fund and implement leadership assessments, training, coaching, and developmental opportunities based on the new leadership competency model.		
Develop assessment tools (360, 180, self-assessment, supervisory) to support the competency model.	HTM with support as required from other offices, e.g., NCOD, EES	Near (within 18 mos)
Assess existing training against the model and identify gaps.	EES	Near (18 mos)
Develop and implement a plan to fill these gaps.	EES/reporting to NLC to ensure funding	Near (plan 20 mos – fill gaps 36 mos depending on \$)

COMMISSION ON CARE FINAL REPORT

Action	Responsible	Timeline
Assess opportunities to share additional leadership training with DoD and create a plan to implement it.	HEC/JEC	Near (9 mos)
Develop and fund a face-to-face training to fulfill competencies for critical career positions.	EES	Near (24 mos)
Develop a masters level training program for clinical leaders in partnership with academic medicine.	EES/Academic Affiliations	Near (36 mos)
Establish sharing agreements with non-profit institutions to permit the exchange of executives for extended rotations.	EES/Academic Affiliations	Near (18 mos)
Create an experiential learning program to parallel the competency model.	EES, HTM reporting to the leadership development subcommittee of the NLC	Near (24 mos)
Establish a coaching program.	HTM/EES	Near (18 mos)
Incorporate tracking of competency assessment, training, coaching, and IDP completion into an appropriate IT platform (e.g., TMS).	HRA/EES/Workforce Management and Consulting	Near (18 mos)
VHA is required to aggressively manage leadership recruitment, retention, development and advancement using the new leadership competency model: all hires and promotions are required to demonstrate these competencies.		
Create functional statements for all key positions based on the competency model.	HTM	Near (18 mos)
Create interview questions incorporating competencies for all key positions.	HTM	Near (12 mos)
Establish a process for certifying internal candidates for advancement to the next position.	Human Capital Management	Near (18 mos)
Incorporate the tracking of competency achievement with performance ratings and create a tracking mechanisms and pool of high potential candidates.	Human Capital Management	Near (18 mos)
Create regulatory requirements for the use of the competency model in hiring, promotion, development opportunities, and discipline; and incorporate procedures for veterans preferences.	Human Capital Management in VHA	Near (36 mos)
Establish an IDIQ, PBA or similar contract for executive recruitment.	Human Capital Management	Now (6 mos)
Establish requirement in policy for all ECF, SES / SES equivalent to complete IDP.	Human Capital Management	Future (following regulatory change)
Create on-ramp for retiring MTF.	Human Capital Management / DoD Coordination	Now (6 mos)
Expand (GHATP) program.	EES	Now (6 mos)
Establish a plan for developing and managing the candidate pool.	NLC subcommittee for leadership	Now (6 mos)
Require a formal on boarding process for leaders at all levels that re-enforces the leadership competency model.		
Establish an onboarding curriculum and process.	Human Capital Management, EES, HTM	Now and Near (18 mos)

APPENDIX B
LEADERSHIP IMPLEMENTATION

Action	Responsible	Timeline
VHA is required to take immediate steps to stabilize the continuity of leadership.		
Extend authority for length of details and ability to compete for the detail position.	Human Capital Management	Now (6 mos)
Establish and fund assistant level positions in all key career development tracks.	CVCS	Now (18 mos)

COMMISSION ON CARE FINAL REPORT

Table B-3. Organizational Structure and Function

Action	Responsible	Timeline
Eliminate duplication within VHA and consolidate program offices to create a flat structure.		
Eliminate the duplication of functions between VHA and VA by closing VHA offices.		
Create innovative organizational structures to support clinical delivery that are aligned to patient's needs rather than professional silos.		
Undertake a reduction-in-force (RIF) in VHACO that promotes delayering and efficiency in communication and decision making.		
Publish a new organizational chart consistent with Figure 9.	CVCS	Now (1 mos)
Prepare an initial RIF for offices eliminated.	VHA Human Capital Management	Now (3 mos)
Engage VERC (or other resources with expertise in business process reengineering) to re-design the processes and structures with remaining offices to ensure end-to-end support for field function and to further reduce duplication; including clinical function re-organization.	Transformation Office/ VERC	Near (3-12 mos)
Each program office in collaboration with VERC or other transformation resources identifies areas of "stop work" with staffing and budget savings.	Transformation Office/ PO/ CVCS	Near (3-12 mos)
Publish clear roles, responsibilities and expectations that apply to all VHACO offices.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VHACO staff to the new expectations for the role of VHACO.	Transformation Office/ EES	Now (1 mos)
Develop training curriculum to support VHACO staff in developing the skills and competencies required.	Transformation Office/ EES	Near (18 mos)
Develop an engagement strategy to inspire VHACO staff to embrace their new role and tie to in-service training roll out.	Transformation Office/ CVCS	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VHACO employees.	Transformation Office/ EES	Now (6 mos)
Adopt customer service training in VHACO and roll it out; include as part of new employee on-boarding in VHACO.	Transformation Office/ EES	Near (12 mos)
Draft basic competencies for VHACO program staff (e.g., customer service, quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ Each PO	Near (18 mos)
Acquire, configure, and train PO staff on data analytics infrastructure to support program office and field tracking of key performance metrics.	Office of Organizational Excellence/OIT	Near (18 mos)

Action	Responsible	Timeline
Clarify and specifically define the roles and responsibilities of the VISNs and facilities, pushing decision making down to the lowest level.		
Publish clear roles, responsibilities and expectations that apply to the VISNs.	Transformation Office/ CVCS	Now (1 mos)
Develop in-service training to orient existing VISN staff to the new expectations for the role of VISN.	Transformation Office/ EES	Now (1 mos)
Develop an engagement strategy to inspire VISN staff to embrace their new role and tie to in-service training roll out.	VISN directors	Now (1 mos)
Modify in-service training and implement in on-boarding process for new VISN employees.	Transformation Office/ EES	Now (6 mos)
Draft basic competencies for VISN staff (e.g., quality improvement, coaching, effective communication, change leadership, data analytics).	Transformation Office/ HCM	Near (12 mos)
Require the basic competencies in functional statements as a basis for hiring and promotion.	Transformation Office/ each PO	Near (18 mos)
Gain agreement from Congress to institute three appropriation lines only: medical, major construction, research.	CVCS/SECVA/OMB	Near (12 mos)
Eliminate segregation of specific-purpose funds to the VISNs and facilities.	CVCS/Office of Finance	Now (6 mos)
Modernize financial management system (FMS) to permit effective cost accounting and tracking of priority spending.	OIT/Office of Finance	Future (36 mos)
Develop training to support effective use of FMS to permit effective account tracking and reporting and roll it out.	Finance/EES	TBD post procurement
Establish quarterly spend reports covering all priority areas (e.g., NRM, IT, facility minor, purchased care, mental health, women's health, administration) by facility and release to Congress and the public.	Finance Office	TBD post procurement
Delegate decisions in recruitment, retention and advancement (e.g., hiring bonus, retention bonus, market pay) for staffing to the facility.	CVCS/HCM	Now (1 mos)
Delegate training and travel decisions.	CVCS/EES/OAA	Now (1 mos)
The USH establishes leadership communication mechanisms within VHACO and between VHACO and the field to promote transparency, dialogue and collaboration.		
Improve communication with field leadership and frontline employees through the liberal use of social media, town halls and other direct engagement channels with a dedicated champion to help the USH and senior staff in this endeavor.	CVCS	Now (3 mos)
Reestablish in-person leadership conferences, at least semi-annually, to foster communication and relationship building between VHACO, VISN and facility leadership.	CVCS/EES/NLC	Now (6 mos)
Add behavioral competencies to performance plans that promote effective communication amongst leaders.	CVCS	Near (12 mos)

COMMISSION ON CARE FINAL REPORT

Action	Responsible	Timeline
Establish expectations and requirements for program office leaders to communicate the USH leadership messages, coordinate PO communications with the USH and with one another.	CVCS	Now (3 mos)
Establish a transformation office with broad authority and a supporting budget to accomplish the change.		
Establish the new transformation office in the organizational chart, populate with expertise in business process re-engineering, and fund initially using savings from closure and consolidation of offices in VHACO and a budget reduction to all other VHACO offices.	CVCS	Now (6 mos)
Create a Transformation Office strategic plan to educate and provide guidance to the new initiatives and support the goals of VA and VHA.	Transformation Office	Near (3-6 mos)
Create a new initiative implementation plan to include follow-on priorities, tasks and milestones. The Transformation Office will support the operation and the plan moving forward.	Transformation Office	Near (3-6mos)
The Transformation Office will be responsible for evaluating all new initiatives and programs using the President's Management Agenda Scorecard or a model that emulates its rating standards of Green represents success; yellow for mixed results; and red for unsatisfactory. These ratings are indicative of standards of success or failure.	Transformation Office	Near (3-6mos)

Table B-4. Performance Metrics and Management

Action	Responsible	Timeline
Create a new performance management system for VHA leaders appropriate for health care executives.		
Establish a workgroup and engage outside experts to create the new performance management system that is benchmarked to private-sector models, is consistent with the new leadership competency model, and recognizes both leadership competencies and success in delivering strategic priorities. The model should include a new rating scale.	Transformation Office/Human Capital Management	Now (6 mos)
Develop and conduct training on the new performance management system for all participants to describe the system, rating process, and expectations.	Human Capital Management	Near (6-12 mos)
Establish a mechanism to capture performance assessment outcomes and track and manage high-potential staff.	Human Capital Management/HRA	Now (3 mos)
Establish a project plan to deliver annual guidance on performance plans at least a month in advance of the new fiscal year (i.e., at the start of the new rating period).	Human Capital Management/CVCS/Sec/OMB	Now (3 mos)
Hold raters accountable for creating meaningful distinctions between leaders.		
Provide training to raters on the application of the new performance management system and expectations for ratings.	Human Capital Management	Future (12 mos)
Require raters to establish plans for subordinates that are timely and meaningful; track and provide feedback on meeting this goal.	Human Capital Management/HRA	Now (3 mos)
By modeling the behavior and communicating the requirement, establish expectations that raters, and secondary-level raters, engage in continuous dialogue and coaching with subordinates about performance throughout the year, not just at mid-year and at the end of the rating period.	CVCS	Now (3 mos)
Establish oversight and feedback process for raters and incorporate this into the raters performance evaluation.	Human Capital Management/CVCS	Now (12 mos)
Provide coaching to raters and focused reviews if their rating profile doesn't provide meaningful distinctions in performance.	Supervisors	Near (12 mos)

COMMISSION ON CARE FINAL REPORT

Table B-5. Leadership Implementation: Human Capital Management

Action	Responsible	Timeline
VA re-align HR functions and processes to be consistent with best practice standards of high-performing health care systems.		
Charge HRA to undertake an HR transformation study and ensure budget and solicitation of customer requirements.	SECVA/DEPSECVA	Now (0-6 mos)
Engage HR and change management experts to develop a benchmark human capital management plan for VA.	HRA	Now (0-6 mos)
Circulate new human capital plan for feedback and finalize.	HRA with input from VHA, Congress, OPM, OMB, SECVA/DEPSECVA, CVCS	Now (6 mos)
That VA and VHA leaders make transformation of Human Capital management a priority, with adequate attention, funding and continuity of vision.		
Endorse human capital management plan and ensure alignment of budget, IT system funding, training resources, and accountability mechanisms to support it.	SECVA/DEPSECVA and CVCS, as applicable	Near (9 mos)
Employ HR and change management experts to fully implement the transformation agenda and the new human capital management plan.	HRA	Near (12-30 mos)
Create an HR IT technology plan.	HRA & OIT	Near (9 mos)
Establish meaningful measures and risk indicators for VA human capital management.	HRA	Future (24 mos)
Incorporate HR measures into systematic reporting to leadership; and as appropriate into performance plans for key subordinate leaders.	HRA, DEPSECVA, CVCS as appropriate	Near (18 mos)
VA develop and implement an effective progressive discipline process for all staffing authorities (i.e., Title 5, Title 38, Title 38 Hybrid, Title 38 7306, and SES).		
Develop clear standards, guidelines, and training on progressive discipline.	HRA (with support from OPM)	Now (6 mos)
Managers, supervisors and HR professionals complete training.	SECVA/ DEPSECVA and CVCS (HTM office)	Near (12 mos)
Train HR staff to be coaches in progressive discipline.	HRA	Now (6-12 mos)
Establish performance metrics for HR professionals and client feedback mechanisms to ensure effective coaching and support for progressive discipline process.	HRA	Near (12 mos)
Establish performance expectations for VA supervisors and managers to apply the progress discipline process.	SECVA/ DEPSECVA, CVCS	Near (12 mos)

APPENDIX C: PILOT PROJECTS FOR EVALUATING EXPANDED CARE

As discussed in Recommendation #18, some Commissioners support the idea of developing pilot programs to test the feasibility of avoiding VA hospital closures by allowing veterans' spouses and currently ineligible veterans to purchase VA care in selected areas.

Problem

In many parts of the country, VHA currently maintains hospitals and other health care facilities that are underutilized or in danger of becoming so. This trend is driven by four main factors: (a) the overall decline in the size of veterans population, (b) the migration of veterans away from some parts of the country, such as New England and the Upper-Midwest, (c) the general trend in health care toward less intensive use of acute-care hospital beds, and (d) increased use of purchased care, which now accounts for 27 percent of all appointments.

A related challenge is maintaining safe volume of care when patient loads decline. As extensive literature attests, surgeons and other health care professionals tend to lose proficiency when they treat too few patients.⁶⁷⁸

Simply closing a low-volume hospital is sometimes the answer. But closing a local VA hospital may mean that area veterans will have reduced access not only to routine, but also to specialty care related to their military service, such as for spinal cord or traumatic brain injuries. In many areas, such care is not available or is in short supply outside VHA.

At the same time, it may not be clinically feasible for VHA to engage in highly specialized care if it lacks the ability to offer other forms of care in the same setting. Patients in a polytrauma unit for example, require a full-spectrum of routine and nonroutine health care.

Increasing the volume of patients treated by VHA in areas where it currently has excess capacity may ameliorate these challenges. Toward that end, VHA could develop pilot programs to test the feasibility of enabling veterans' spouses and currently ineligible veterans in these areas to purchase VHA care through their health plans. These pilots could be tested in conjunction with the growth of the high-performance, integrated VHA networks recommended elsewhere in this report. These networks will allow VHA far more flexibility than in the past to expand or contract its local capacity in different markets as appropriate.

⁶⁷⁸ Ninh T. Nguyen et al., "The Relationship Between Hospital Volume and Outcome in Bariatric Surgery at Academic Medical Centers," *Annals of Surgery*, 240, no. 4 (2004): 586-594. D. R. Urbach and N. N. Baxter, "Does It Matter What a Hospital Is 'High Volume' For? Specificity of Hospital Volume-Outcome Associations for Surgical Procedures: Analysis of Administrative Data," *Quality and Safety in Health Care*, 13, no. 5 (2004): 379-383, <http://doi.org/10.1136/bmj.38030.642963.AE>. Edward L. Hannan et al., "Coronary Angioplasty Volume-Outcome Relationships for Hospitals and Cardiologists," *Journal of the American Medical Association*, 277, no. 11 (1997): 892-898, <http://doi.org/10.1001/jama.1997.03540350042031>.

COMMISSION ON CARE FINAL REPORT

Background***Current Nonveteran Access to VHA Care***

VHA already treats many nonveterans. VHA estimates it treated 694,120 unique nonveteran patients at a total cost of \$1.9 billion in 2015,⁶⁷⁹ or 3.6 percent of total VHA obligations.⁶⁸⁰

By far the largest subgroup within the nonveteran patient population are participants in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). CHAMPVA beneficiaries are the dependents of permanently and totally disabled veterans, survivors of veterans who died from service-connected conditions or while on active duty, or spouses of veterans who at the time of death were rated permanently and totally disabled from a service-connected condition.

Congress authorized CHAMPVA in 1973. The authorization specifies that VHA is the secondary payer for those with Medicare Part A and B coverage. In cases for which VA medical facilities are equipped to provide the care, VA may use facilities not being used for the care of veterans to provide services to the dependent or survivor.

Congress has also directed VHA to offer specific health care services to many other classes of nonveterans. These include mental health and counseling services for family caregivers of seriously injured veterans of post-9/11 service. Several provisions of law also authorize VA care for certain family members of veterans who were exposed to toxic substances. In the case of veterans with 50 percent or more service-connected disability, VHA must provide by law “consultation, professional counseling, marriage and family counseling, training and mental health services as are necessary in connection with” the veteran’s treatment.⁶⁸¹

Analysis

Others who have developed strategic plans for the long-term future of VA health care have recommended expanding upon these precedents, specifically by allowing currently ineligible veterans and the spouses of veterans to purchase VHA care.⁶⁸² In effect, providing such care would allow VHA to operate as an accountable care organization, capable of receiving reimbursement from patients covered by Medicare, Medicaid, as well as by private insurance plans. Among the potential benefits envisioned are the following:

- optimizing patient safety, productivity, and cost-effectiveness by ensuring sufficient patient volumes in currently under-utilized facilities
- preserving mission critical veterans’ programs that would otherwise need to be terminated in many parts of the country
- optimizing the integration of VHA and non-VHA care within communities

⁶⁷⁹ Allocation Resource Center, information provided to Commission on Care, December 8, 2015.

⁶⁸⁰ Department of Veterans Affairs, “Volume II: Medical Programs and Information Technology Programs, Congressional Submission, FY 2016 Funding and FY 2017 Advance Appropriations,” accessed May 27, 2016, <http://www.va.gov/budget/products.asp>.

⁶⁸¹ Counseling, Training, and Mental Health Services for Immediate Family Members and Caregivers, 38 U.S.C. § 1782.

⁶⁸² Concerned Veterans for America, *Fixing Veterans Health Care: A Bipartisan Policy Taskforce*, accessed May 27, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

- providing a *public option* for health care to a wider range of veterans as well as nonveterans in communities where health care choices are currently limited
- bringing in new sources of revenue to contribute to the funding for veterans' healthcare

The pilot projects described below would specifically evaluate whether such a strategy will allow VHA to optimize the quality and cost-effectiveness of its health care system by avoiding low volumes of routine and specialty care in certain sections of the country. These pilot projects would also allow VHA to evaluate whether such a strategy could provide new revenues for sustaining the VA health system while providing other benefits to veterans and the public at large.

The chart below sketches six possible pilot projects designed to test different specific policy configurations. The configurations include projects in which VA care is marketed to health care plans on fee-for-service (FFS) basis, and plans in which VA facilities are markets to health care plans as Accountable Care Organizations that provide integrated health services to a fixed population of insured patients for a fixed cost.

*Demonstration Projects to Assess VHA's Capability to Treat
Nonveteran Spouses and Ineligible Priority 8 Veterans*

	Eligibility	Capitation/Fee For Service	Timing
Demonstration 1: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) With Private Insurance	FFS	Years 2-7
Demonstration 2: FFS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance	FFS	Years 2-7
Demonstration 3: FFS plan covering spouses	Non-veteran spouses of veterans (not CHAMPVA eligible) with private insurance	FFS	Years 3-8
Demonstration 4: FSS plan covering veterans currently ineligible for VA care	Priority 8 veterans now ineligible for enrollment with private insurance and/or Medicare	FFS	Years 3-8
Demonstrations 5 and 6: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses	Enrollment: May choose higher cost plan with more coverage and less copayment; lower cost option with less coverage and higher copayments.	Years 4-9

COMMISSION ON CARE FINAL REPORT

	Eligibility	Capitation/Fee For Service	Timing
Demonstrations 7 and 8: Accountable health care organization plans for spouses and currently ineligible veterans	Ineligible Priority 8 and non-veteran spouses with private insurance and/or Medicare	Enrollment: May choose higher cost plan with more coverage and less copayment; or lower cost option with less coverage and higher copayments. Pilot sites would be deemed Accountable Health Care Organizations for Medicare Advantage plans.	Years 5-10

Certification of Access: Any participating VHA facility must certify that its waiting times for primary care, specialty care and behavioral health are less than 30 days.

Site selection: Sites should include facilities in different regions with various population densities (urban, suburban, rural) and levels of service complexity. VHA may also consider such factors as stability of medical center leadership, and whether local markets are underserved or subject to high degrees of market concentration among either providers or payers.

Assumptions

- Many provisions are subject to Congressional authorization.
- Participating VHA facilities will be able to retain any “profit” associated with treatment of new users without offset;
- Congress will (preferably) waive the current prohibition on Medicare funding federal health care programs,
- VHA will not be subject to proving “level of effort” in order to receive Medicare funds

Assessment

After the first year of operations, VHA will assess these projects according the following criteria:

- Was access to care or patient satisfaction among veterans already enrolled in the system affected by the demonstration?
- What was the level of patient satisfaction among new users purchasing VA care?
- Did VHA cover the costs of delivering care to its patients purchasing care? If so, what were its net revenues and how were they used?
- If VHA collected Medicare funds, did funding cover costs of delivering care?

APPENDIX C
PILOT PROJECTS FOR EVALUATING EXPANDED CARE

- Were there administrative challenges in opening the VHA to new users? If so, what lessons were learned?
- How did VHA promote the demonstration project to those eligible?
- What are the recommended strategies for further implementation?
- Were there non-financial benefits to treatment of new users, such as diversifying case mix, providing sufficient volume to allow certain VHA services to remain available, or keeping scarce health professionals employed in an area that is medically underserved?
- How did the demonstrations affect the overall quality of care, market structure, pricing, and range of health care options available to both veterans and nonveterans in the surrounding community?

COMMISSION ON CARE FINAL REPORT

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX D:

HISTORY AS A CONTEXT FOR SYSTEMIC TRANSFORMATION

History provides opportunities to see the problems and challenges facing VHA today through the lens of recurring themes from the past. Veterans' health care has, over the course of its history, been marked by periods of both progress and problems. Understanding the challenges of the past and the solutions used to address them provides context for building a plan for reforming veterans' health care in a manner that is flexible and sustainable.

Challenges and Growth

The federal government's role as a care provider for veterans has evolved, paralleling, to some extent, medicine's evolution. Prior to World War I, the only benefits afforded then-eligible veterans were pensions and domiciliary care (which involved only incidental medical treatment), provided under the National Home for Disabled Volunteer Soldiers and Sailors established after the Civil War.⁶⁸³

World War I brought real change. At the time, no single agency was responsible for the anticipated deluge of sick and wounded soldiers. The more than 200,000 wounded who returned home from battle quickly exceeded capacity of the U.S. Public Health Service (PHS), the National Home, and other agencies. According to one account of the period, "[c]haos and confusion reigned for more than two years . . . [n]ew hospital construction languished," and "[b]y 1921, veterans' care had become a national embarrassment."⁶⁸⁴ At the recommendation of a presidential committee, Congress passed legislation in 1921 to consolidate the several veterans-related bureaucracies into a single Veterans Bureau, to which the President Warren Harding transferred 57 PHS hospitals. A new administrator, Frank T. Hines, proposed care and treatment of veterans' non-service-connected ailments when facilities and bed space were available. Congress adopted the proposal in the World War Veterans Act of 1924.⁶⁸⁵

Under Hines' tenure, VA grew from 64 to 91 hospitals, nearly doubling bed capacity. Civil Service Commission personnel rules and low pay led to generally poor quality VA physicians, yet Congress rebuffed VA proposals to set up a VA Medical Corps.⁶⁸⁶ With many physicians having left VA to serve in World War II or for more lucrative practice, the VA health care system was left critically understaffed.⁶⁸⁷

⁶⁸³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 4.

⁶⁸⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 13-14.

⁶⁸⁵ *Ibid.*, 19.

⁶⁸⁶ *Ibid.*, 21.

⁶⁸⁷ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 149.

COMMISSION ON CARE FINAL REPORT

World War II and the need to care for millions of service members, including 671,000 wounded, highlighted the problems facing VA. Scathing reports of shoddy veterans' care, including an exposé characterizing veterans' hospitals as backwaters of medicine, magnified the problems.⁶⁸⁸

Congressional hearings led to a shakeup in leadership and General Omar Bradley was appointed to head the agency, with its network of 97 hospitals, and a need for more.⁶⁸⁹ Dr. Paul Magnuson, who served as VA's chief medical director (CMD) from 1948 to 1951, later described the conditions at the time:

*The majority of Veterans Administration hospitals were stuck in far off places, some of them on Indian reservations, others as much as fifty miles from the nearest through-line railway stop. The doctors were all full-time Civil Service employees, hemmed in by regulations and practically forbidden to do any research, attend any medical meetings or otherwise keep in touch with scientific progress. Operating rooms closed at noon so everybody could spend the afternoon happily doing required paperwork, while patients waited days and weeks for surgery.*⁶⁹⁰

With President Harry Truman's statement that "the Veterans Administration will be modernized," new VA leadership worked with Congress to pass far-reaching legislation, Public Law 293, which created a VA Department of Medicine and Surgery (DM&S), and freed VA physicians, dentists, and nurses from the Civil Service Commission and its rules.⁶⁹¹ Within weeks, the chief medical director of the new DM&S issued a policy memorandum that outlined a cooperative affiliation agreement between VA and medical schools under which deans' committees would recommend consultants and attending physicians for appointment to VA, and residency-training programs would be established at VA hospitals. The law, and Policy Memorandum #2, broke a recruitment logjam and enabled the short-staffed department to hire medical professionals needed for the dozens of new VA hospitals being built. Soon after, medical students and residents began working in 32 VA hospitals. The reforms instituted under Bradley and his team were palpable,⁶⁹² with the physician staff at VA hospitals increasing from 2,300 (1,700 of whom were detailed by the military) in June 1945 to 4,000 full-time staff a year later.⁶⁹³ By 1948, VA had 125 hospitals in operation with 60 medical school affiliations and 2,000 residents.⁶⁹⁴

After this turn-around, Bradley left to become Army Chief of Staff, and under his successor, "who did not enjoy the same level of prestige and support that Bradley did . . . VA quickly

⁶⁸⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 22.

⁶⁸⁹ Ibid., 23-25.

⁶⁹⁰ Ibid., 22.

⁶⁹¹ "31: The President's News Conference," Harry S. Truman Library & Museum, accessed June 3, 2016, <http://trumanlibrary.org/publicpapers/viewpapers.php?pid=38>.

⁶⁹² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 27.

⁶⁹³ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 214.

⁶⁹⁴ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 28.

reverted to its pre-Bradley ways and remained that way for the next forty years,”⁶⁹⁵ according to one account.

By the early 1950s, the veteran population had grown to more than 20 million.⁶⁹⁶ VA was operating 162 hospitals, with an average census of more than 104,000 patients.⁶⁹⁷ A VA historian observed that “waiting lists contained 22,613 applicants awaiting admission, none of whom were service-connected, although some of the latter were hospitalized in other than VA hospitals.”⁶⁹⁸ At the time, non-service-connected veterans seeking care had to state under oath that they could not afford to pay for hospitalization, and admission was granted only when beds were available in VA or other federal hospitals.⁶⁹⁹ Critics called for reducing free medical care of non-service-connected veterans, and questioned whether some were getting care that they could afford. This issue led VA to institute a policy of formal counseling under which hospitals would supply the veterans with an estimated cost of care to assist them in determining their ability to pay.⁷⁰⁰

In contrast to the generous Bradley-era funding, the 1950s funding cuts necessitated layoffs, bed-closures, and moth-balling of newly constructed hospital wards.⁷⁰¹ During this period, annual debates over the DM&S budget centered on the number of beds VA should operate. VA leaders contended that the number should be 125,000, yet the director of the Bureau of the Budget (the predecessor to the Office of Management and Budget [OMB]) asserted 87,000 was sufficient.⁷⁰²

The expiration of the incumbent CMD’s term led to the appointment in 1955 of medical educator Dr. William Middleton, dean of the Wisconsin Medical School, and a long-time member of a VA special medical advisory group. One of his first acts as CMD was to champion medical research in VA and broaden its scope to include geriatric research. Soon after, Congress began earmarking funds for VA research, and expanded DM&S’ statutory role to include medical research.⁷⁰³ During Middleton’s tenure, from 1955 to 1963, VA research funding grew from some \$6 million to more than \$30 million.⁷⁰⁴ Middleton’s work laid the foundation for a research program long recognized for pioneering important medical technologies, including medical use of radioisotopes, dialysis, cardiac pacemakers, liver transplantation, as well as seminal studies that documented the benefits of coronary artery bypass surgery and drug treatment of hypertension.⁷⁰⁵ The program also stood out for its capacity to design and rapidly implement large-scale cooperative trials, first mounted in the 1950s with successful evaluation

⁶⁹⁵ Ibid., 29.

⁶⁹⁶ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 254.

⁶⁹⁷ Ibid.

⁶⁹⁸ Ibid.

⁶⁹⁹ Ibid., 253.

⁷⁰⁰ Ibid., 253-254.

⁷⁰¹ Ibid., 256.

⁷⁰² Ibid., 258.

⁷⁰³ Ibid., 262-263.

⁷⁰⁴ Ibid., 263-264.

⁷⁰⁵ Stanley Zucker et al., “Veterans Administration Support for Medical Research: Opinions of the Endangered Species of Physician-Scientists,” *The FASEB Journal*, 18, no. 13, (2004): 1481-1486, <http://doi.org/10.1096/fj.04-1573lfe>.

COMMISSION ON CARE FINAL REPORT

of chemotherapy for tuberculosis.⁷⁰⁶ Working on issues relevant to veterans, VA researchers developed functional electrical stimulation systems to allow patients to move paralyzed limbs, helped develop the first ankle-foot prosthesis, and launched the largest-ever trial of psychotherapy to treat posttraumatic stress disorder.⁷⁰⁷

Middleton expanded the VA educational program. In addition to growing the number of medical residents it helped train, VA provided training to a large share of clinical psychologists, graduate dentists, student nurses, occupational and physical therapists, social work students, and dietetic interns. Middleton instituted numerous advances in VA care such as introducing outpatient care for preadmission workups and post-hospital treatment that allowed earlier release from inpatient stays. He moved VA away from operating hospitals for specific diseases (as had been done for tuberculosis and mental illness).⁷⁰⁸

The enactment of Medicare in 1965 raised questions about the effect that program would have on the VA health care system. The House Veterans Affairs Committee sent a questionnaire to a group of 10,000 veterans explaining the new program and asking the veteran to if they preferred VA care or treatment in a community hospital under Medicare.⁷⁰⁹ Some 59 percent responded, and nearly two-thirds of respondents preferred VA.⁷¹⁰ At the time, the policy governing those eligible for VA care based on financial need was that Medicare benefits were to be considered in determining an individual's ability to pay for needed care.⁷¹¹

The enactment of Medicare and other changes in health care in 1977, led to a commission being established by the National Academy of Sciences (NAS) which issued a report pursuant to a congressional directive to evaluate the VA health care system. Among its findings, the commission reported that VA had a surplus of acute beds and recommended that new facilities be constructed only after examining bed availability in the community. It also recommended that underutilized VA hospitals be closed or converted to long-term care facilities, and resources redistributed to permit a shift from inpatient to outpatient care. The NAS commission also recommended that VA experiment with models for community-based integrated care.⁷¹² The commission's recommendation for integrating the VA system into the nation's civilian health care program⁷¹³ provoked objection, particularly in Congress.⁷¹⁴ Hearings produced sharp rejections of the NAS commission findings and its call to end VA's role in providing health care to veterans.

⁷⁰⁶ Ibid.

⁷⁰⁷ Veterans Health Administration, *History of VA Research Accomplishments*, accessed June 3, 2016, http://www.research.va.gov/researchweek/press_packet/Accomplishments.pdf.

⁷⁰⁸ Veterans Administration, *Medical Care of Veterans*, report prepared by Robinson Adkins, 90th Cong., 1st sess., 1967, House Committee Print 4, 265-267.

⁷⁰⁹ Ibid., 390.

⁷¹⁰ Ibid.

⁷¹¹ Ibid.

⁷¹² *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

⁷¹³ J. William Hollingsworth and Philip K. Bondy, "The Role of Veterans Affairs Hospitals in the Health Care System," *New England Journal of Medicine*, 322, no. 10, (1990): 1851-1857, <http://doi.org/10.1056/NEJM199006283222605>.

⁷¹⁴ *Hearings before the Subcommittee on Medical Facilities and Benefits of the Committee on Veterans Affairs*, 95th Cong., 1st Sess. (July 21, 1977), Statement of Dr. Saul Farber.

The VA of the 1970s and 1980s is remembered as bureaucratic, reliant on paper health care records, and driven by patient admissions (on which budgets were based).⁷¹⁵ The quality of VA care was also an issue. Complaints from Vietnam veterans and critical media accounts fueled outrage, and led to the view that the system was broken. The question, how to fix it, reopened an earlier dialogue around making VA a cabinet-level department, a view strongly supported by veterans service organizations (VSOs) and veterans' leaders in the House of Representatives. In 1988, after years of debate, and opposition from administration offices and advisors, President Reagan signed legislation creating a Department of Veterans Affairs.⁷¹⁶ The new department, with DM&S now renamed the Veterans Health Services and Research Administration (to emphasize its research legacy in such fields as infectious disease, pacemaker technology, and prosthetics), employed some 194,000 people with a \$12 billion budget.⁷¹⁷

Facing an aging veteran population⁷¹⁸ expected to overwhelm the system by 2010, the new secretary, Edward Derwinski, in 1989 requested Congress establish an independent commission to review the alignment and mission structure of VA's hospitals. Congress rebuffed the request after VSOs, suspecting a plan to close hospitals, lobbied against it.⁷¹⁹ Derwinski created his own "Commission on the Future Structure of Veterans Health Care" that was to review all VA hospitals and recommend needed mission changes. Instead, the so-called Mission Commission called for expanding eligibility law to enable veterans to obtain the full continuum of VA health care services. Although the commission identified the need for fundamental restructuring of the VA health care system, the subject was soon overtaken by national health reform proposals, and what role VA might have under a universal coverage system.⁷²⁰

Dr. James Holsinger, a new under secretary for health (USH), made care quality a top goal and issued a Blueprint for Quality tool in 1992, setting the stage for more far-reaching changes instituted by his successor, Dr. Kenneth Kizer. Care quality, a perennial topic, had led to the previous under secretary's resignation following reports of multiple veterans' deaths under questionable circumstances at VA's North Chicago medical center.⁷²¹ Two years later, Derwinski lost his job after creating ire among veterans' organizations in response to his proposed pilot program to open two VA hospitals to poor, rural nonveterans.⁷²²

⁷¹⁵ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 30-31.

⁷¹⁶ Ibid., 33-40.

⁷¹⁷ Ibid., 50.

⁷¹⁸ As the General Accounting Office reported in 1990, "The Department of Veterans Affairs (VA) faces a major challenge: planning how to meet the long-term care needs of a rapidly aging veteran population. The number of veterans 65 years old and over is projected to grow to 9 million by 2000—a 50percent increase over the 1988 level.

U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷¹⁹ U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Nursing Home Planning*, GAO/HRD-90-98 (Washington, DC, 1990), 51, accessed June 20, 2016, <http://www.gao.gov/assets/150/149139.pdf>.

⁷²⁰ U.S. Government Accountability Office, *Veterans' Health Care: Veterans' Perceptions of VA Services and VA's Role in Health Care Reform*, GAO/HEHS-95-14 (Washington, DC, 1994), accessed June 20, 2016, <http://archive.gao.gov/f0902a/153054.pdf>.

⁷²¹ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 53.

⁷²² "Angry Veterans Groups Say They Made Bush Oust Agency's Head," Eric Schmitt, accessed June 3, 2016, <http://www.nytimes.com/1992/09/29/us/angry-veterans-groups-say-they-made-bush-oust-agency-s-head.html>.

Transformational Leadership

VA's second secretary, Jesse Brown, brought his passion as a veterans advocate to the department's leadership.⁷²³ Among Brown's most important early acts was selecting Dr. Kenneth Kizer, a prominent California physician-administrator and educator, from among 90 candidates identified by a search committee for the USH post.⁷²⁴ With experience heading the California department of public health, Kizer saw health care as a system, and data as a tool to improve it.⁷²⁵

Kizer, in essence, launched a major reengineering of the VA health care system through better use of information technology, measurement and reporting of performance, integration of services, and realigned payment policies.⁷²⁶ His vision was large and bold, underscored by his belief that "we have to be able to demonstrate that we have an equal or better value than the private sector, or frankly we should not exist."⁷²⁷ At VA, Kizer found a workforce trapped in a micro-managerial, command-and-control system in which there was little accountability.⁷²⁸ He set the tone for what was to come at a meeting with senior managers at which he stated,

*The old culture must give way to a new culture . . . that is based on innovation and creativity; a culture based on personal initiative and individual and collective accountability; a culture that is based on outcomes and heightened productivity; and a culture that is committed to change.*⁷²⁹

Among his first steps was the development of what was to become a Vision for Change, a new organizational model to restructure both field operations and central office management. At its core was the creation of 22 veterans integrated service networks, or VISNs, (replacing four regions which had been responsible for overseeing 40 to 45 hospitals each), with decision making shifted away from VA Central Office (VACO) to the new VISN directors. VISNs were to be the basic budgetary and planning unit, and to have staffs of no more than 7 to 10 employees.⁷³⁰ Each VISN was in charge of all the care provided to veterans in that network, and each was funded on a capitated basis rather than based on historical costs.⁷³¹ The VACO structure would be marked by its *flatness*, foregoing a tiered hierarchy.⁷³²

⁷²³ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 89.

⁷²⁴ Ibid., 92.

⁷²⁵ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 50-51.

⁷²⁶ Ashish K. Jha et al., "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care," *New England Journal of Medicine*, 348, no. 22, (2003): 2218-2227, accessed June 20, 2016, <http://doi.org/10.1056/NEJMsa021899>.

⁷²⁷ Phillip Longman, *Best Care Anywhere: Why VA Health Care Would Work Better for Everyone* (San Francisco: Berrett-Koehler Publishers, Inc., 2012), 51.

⁷²⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 97-8.

⁷²⁹ Ibid., 105.

⁷³⁰ Ibid., 110.

⁷³¹ "What Can the Rest of the Health Care System Learn from the VA's Quality and Safety Transformation," Ashish K. Jha, accessed June 3, 2016, <https://psnet.ahrq.gov/perspectives/perspective/31>.

⁷³² James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 111.

The system Kizer and his team inherited was characterized by a multitude of problems.⁷³³ Kizer and his team literally reengineered the veterans' health care system based on a set of transformation strategies: to create management accountability, integrate and coordinate services, improve the quality of care, align system finances with desired outcomes, and modernize information management.⁷³⁴

Kizer also launched a technological revolution in VHA with deployment of a powerful electronic medical record,⁷³⁵ and development of systems such as medication bar-coding to tackle medical errors and ensure patient safety.⁷³⁶

Some of Kizer's successes involved winning support within the administration and from Congress for bold initiatives. He won a critical concession from OMB that VA savings could be reinvested into VA, permitting his transformation efforts to be funded through internal cost-savings rather than new funding,⁷³⁷ and garnered support from Congress for a dramatic reduction of acute care beds and for closing massive regional offices.⁷³⁸ These steps and congressional passage of legislation to reform health care eligibility laws paved the way for establishing universal primary care in VA and developing community-based clinics across the country.⁷³⁹

Sweeping Reform

During a 5-year period, Kizer dramatically changed almost every major VHA management system and improved operational performance through the use of performance measures and contracts. He closed nearly 29,000 acute care beds, merged 52 medical centers into 25 multi-campus facilities, reduced staffing by almost 26,000, opened more than 300 community-based outpatient clinics, and treated 24 percent more patients. In addition to bringing measurable quality into VA health care, Kizer achieved marked reductions in waiting times and medical errors.⁷⁴⁰

Kizer's tenure brought dramatically improved quality, service, and operational efficiency to VHA yet threatened powerful interests. As he noted, "...places like Florida, Arizona, and the

⁷³³ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 316, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁴ Ibid., 318-323.

⁷³⁵ VA in 2006 won the Harvard Innovations in Government Award for its VistA system. James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 211.

⁷³⁶ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 157-165.

⁷³⁷ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 323, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷³⁸ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 128-129.

⁷³⁹ Kenneth Kizer and R. Adams Dudley, "Extreme Makeover: Transformation of the Veterans Health Care System," *Annual Review of Public Health*, 30, (2009): 319-320, accessed June 20, 2016, <http://doi.org/10.1146/annurev.publhealth.29.020907.090940>.

⁷⁴⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 170.

COMMISSION ON CARE FINAL REPORT

Sun Belt States were not getting their fair share [of funds] and their elected officials were unhappy about it. People from Pennsylvania and Illinois and New York were not about to give their money away, so there was this big disconnect.”⁷⁴¹ Kizer’s team developed a capitation system to more equitably allocate funds across the system. Aware of the political ramifications, he implemented incremental changes during a 2- to 3-year period to make them as painless as possible. But the congressional goodwill he had enjoyed unraveled when Kizer and his VISN directors began cutting and consolidating facilities to accommodate VISN funding cuts. The threat of hospital mergers and consolidations ultimately led several senators to block his confirmation to a second term.⁷⁴²

Under new eligibility reform law, all veterans became *eligible* for VA health care, though its authors did not envision that the system could or would serve all eligible individuals, or even all who might someday seek VA care. The law’s priority-based enrollment system was intended to give VA a tool to align demand for care with its funding level.⁷⁴³ The law instead unleashed political pressure to expand enrollment, opening the door to an influx of veterans who historically had not been VA health care users and many of whom were already covered under military retirement benefits, private insurance, or Medicare.⁷⁴⁴ That expansion led to a tremendous demand for prescription drug benefits by new enrollees and in 2003, Secretary Tony Principi ended enrollment for higher income (category 8) veterans “to keep the system solvent.”⁷⁴⁵ At about the same time, other related pressures led Principi to establish an advisory body, the Capital Asset Realignment for Enhanced Services (CARES) Commission, to develop a comprehensive capital asset plan. Principi cited the age of VA facilities and the changes in medical practice, but also reminded a congressional oversight committee of a 1999 Government Accountability Office finding that “maintaining obsolete or duplicative structures diverts \$1 million a day, every day, every year, away from the care of veterans.” Principi did not want to repeat Kizer’s experience and hoped to avoid political backlash.⁷⁴⁶

The CARES Commission released a final report in February 2004 that recommended relatively few actual facility closures, though it proposed substantial facility mission changes at a number of facilities.⁷⁴⁷ As the then USH later recounted, “CARES, like so many things in Washington, was well-intended, but it was derailed politically once it began moving toward actual targeted action within specific congressional districts.”⁷⁴⁸

Despite such defeats, Principi and VA under secretaries following Kizer met formidable challenges, left legacies, and saw the veterans’ health care system continue to be heralded for several years.⁷⁴⁹ A cascade of other events muddled, and even blackened, VHA’s reputation:

⁷⁴¹ Ibid., 133-134.

⁷⁴² Ibid., 168-169.

⁷⁴³ Veterans Affairs Comm., Veterans’ Health Care Eligibility Reform Act of 1996, H. R. Rep. No. 104-690 (1996), accessed June 3, 2016, <https://www.congress.gov/congressional-report/104th-congress/house-report/690/1>.

⁷⁴⁴ James Rife, *Not Your Father’s VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 193.

⁷⁴⁵ Ibid., 194.

⁷⁴⁶ Ibid., 195.

⁷⁴⁷ Ibid., 196.

⁷⁴⁸ Ibid.

⁷⁴⁹ “The Best Care Anywhere,” Phillip Longman, *Washington Monthly*, accessed June 3, 2016,

accounts of veterans' suicides (and an alleged cover-up); incompetent surgeries and patient deaths at a high-visibility VA medical center (VAMC); failed software acquisitions;⁷⁵⁰ hard-hitting inspector general audit reports on issues such as system flaws, quality of care issues, and lack of timely care that fueled congressional oversight and other constraints. The 2014 scandal that erupted at the Phoenix VAMC represented a decisive turning point and set the stage once again for transforming veterans' health care.

Among initial steps on that long road to transforming the system, the Senate in July 2014 unanimously confirmed Robert A. McDonald, former chief executive officer of Proctor & Gamble, as secretary of veterans affairs. With a business career of delivering better results, McDonald, along with DEPSECVA Sloan Gibson and USH Dr. David Shulkin, has been working to improve VA's health care system and service delivery, and to set a framework for long-term reform. Days after McDonald's confirmation, Congress passed the Veterans Access, Choice, and Accountability Act of 2014, omnibus legislation to improve veterans' access to care. This legislation established the *Choice Program*, mandated an independent assessment of VHA, and established the Commission on Care.

<http://www.washingtonmonthly.com/features/2005/0501.longman.html>. "Revamped Veterans Health Care Now a Model," Gilbert Gaul, accessed June 3, 2016, <http://www.washingtonpost.com/wp-dyn/content/article/2005/08/21/AR2005082101073.html>. "The Best Medical Care in the U.S.: How Veterans Affairs Transformed Itself—and What it Means for the Rest of Us," Catherine Arnst, accessed June 3, 2016, <http://www.bloomberg.com/bw/stories/2006-07-16/the-best-medical-care-in-the-u-dot-s-dot>.

⁷⁵⁰ James Rife, *Not Your Father's VA: The Transformation of VA Health Care in the Late 20th Century* (Washington, DC: Department of Veterans Affairs, 2014), 216-217.

COMMISSION ON CARE FINAL REPORT

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX E: THE EVOLVING HEALTH CARE INDUSTRY

Health care has evolved in major ways since the federal government began providing care to veterans after the Civil War, and it will continue to evolve substantially in the future. There are a number of factors that drive evolution in health care, such as population and lifestyle changes, changes within the various health care professions, medical and information systems technology, and systems changes in management and operations.⁷⁵¹ IBM Center for Applied Insight reports that there are 18 trends to watch in health care.⁷⁵² These trends closely encompass those highlighted below. The categories in which the trends fall mirror key topic addressed in the Commission's report to include data system interoperability (10 trends), consumer technology (two trends), health care providers (two trends), government regulations (two trends), and human resources and leadership (two trends). With health care changing so rapidly, and in so many different ways, it is imperative that veterans' health care continually evolve to remain aligned with current and future trends. This section highlights key trends that, based on past experience and current practice, will likely shape health care in the future, were considerations in formulating the Commission's recommendations, and will likely affect transformation of veterans' health care.

Emergence of Large Health Care Systems

The health care industry is moving away from stand-alone community hospitals that serve the needs of a local constituency to large, multiple-campus health care systems.⁷⁵³ The industry will see more high profile mergers and acquisitions in the second half of 2016.⁷⁵⁴ The December 2015 Health Research Institute's report indicates that well-known health care systems may have a market advantage as Americans are willing to travel further for care from a well-known system. This may explain the development and affiliation for Mayo Clinic in Arizona and Florida, and Cleveland Clinic opening in Florida. The report also states that although people are willing to drive for care they are not willing to pay prices higher than the local market. Because of increasing use of outpatient services and same-day surgery, facilities within these health care systems require fewer inpatient beds.⁷⁵⁵ With the advancement of psychotropic drugs, the perceived need for large mental hospitals has declined.⁷⁵⁶ Because of shorter recovery stays, increased outpatient services, telemetry and other monitoring programs, and new medical inventions, hospitals are now built as smaller facilities with parts or sections that can be quickly

⁷⁵¹ Lynn Etheredge, Stanley B. Jones, and Lawrence Lewin, "What is Driving Health System Change?" *Health Affairs*, 15, 4, (1996): 93-104.

⁷⁵² "Healthcare Internet of Things 18 Trends to watch in 2016," Bill Chamberlain, IMB Center for Applied Insights, March 1, 2016, accessed June 20, 2016, <https://ibmcai.com/2016/03/01/healthcare-internet-of-things-18-trends-to-watch-in-2016>.

⁷⁵³ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed April 29, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁵⁴ Ibid.

⁷⁵⁵ Ibid.

⁷⁵⁶ "How Release of Mental Patients Began," Richard Lyons, accessed May 1, 2016, <http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

COMMISSION ON CARE FINAL REPORT

modified for future changes and medical advances.⁷⁵⁷ VHA will need to consider this trend in evaluating its current physical plant and planning for future facility needs.

Management Changes

As health care systems become increasingly complex, there is a need to manage these institutions using current management theories and models.⁷⁵⁸ During the past few decades, hospital and health care management changed from being managed by a traditional top-down model to continuous quality improvement models that respond to issues such as staff satisfaction, medication errors, safety matters, and wasteful use of supplies. To address errors, hospitals have implemented Six Sigma principles. To address waste, hospitals have implemented LEAN principles. Embracing these changes in management approach and implementing Six Sigma and LEAN principles will support VHA's transformational process.

Health Care Payment

The health care industry is in the midst of transforming its payment model away from a fee-for-service model to value-based payments, a system that drives improved health outcomes.⁷⁵⁹ This transformation is tied to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which health care experts expect to shape care delivery and payment reform across the U.S. health care system over the coming decades. Congress created MACRA as a transformative law to fast track the health care system's transition from a traditional fee-for-service payment model to new risk-bearing, coordinated care models.⁷⁶⁰ Because this legislation is still in rulemaking, it is premature for the Commission to weigh in on its potential effect on VA. The MACRA legislation expands the trend toward creation of accountable care organizations (ACOs) and bundled payments for care. ACO models have been reported to drive reduced hospitalization and generate cost savings.⁷⁶¹

Specialty Care Facilities

With changes in the federal payment for hospitals, some high-cost and longer-stay care treatments have been moving out of community hospitals to specialty hospitals. For example, long-term acute care hospitals primarily treat patients on ventilators; rehabilitation facilities treat short-term, post-acute patients who need primarily physical and occupational therapy services for orthopedic or stroke incidences; and cancer hospitals provide innovative treatments for Stage 4 cancer. As a result, community hospitals may no longer need beds to take care of these special patients. VHA will need to consider this trend in planning integrated care networks and evaluating its facility needs in conjunction with these networks.

⁷⁵⁷ "The Small Hospital of the Future," Shati Matambanadzo, accessed May 3, 2016, <http://www.healthcaredesignmagazine.com/article/small-hospital-future>.

⁷⁵⁸ "How to Solve the Cost Crisis in Health Care," Robert S. Kaplan and Michael E. Porter, accessed May 2, 2016, <https://hbr.org/2011/09/how-to-solve-the-cost-crisis-in-health-care>.

⁷⁵⁹ "The Medicare Access CHIP Reauthorization Act (MACRA)" National Partnership for Families and Women, accessed June 6, 2016, <http://www.nationalpartnership.org/issues/health/macra.html>.

⁷⁶⁰ "MACRA: Disrupting the health care system at every level," Deloitte, accessed June 23, 2016, <http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/macra.html>.

⁷⁶¹ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, Inquisitr: Medicine, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

Outpatient Care and Lifestyle-oriented Venues for Care

With improvements in surgical procedures, many surgeries that required post-surgery hospital stays are now routinely performed in outpatient settings.⁷⁶² Many nonsurgical procedures are being performed in outpatient clinics as well, such as medical imaging, cardiac catheterization, substance abuse treatment, gastrointestinal screening and cancer treatment.⁷⁶³ As care that was once provided only in hospitals is now provided in specialized medical clinics, care that was once provided only in physicians' offices is now being provided in alternative settings. As reported in Health Affairs, "another health care trend consumers are using to save both time and money is that rather than making appointments with their doctors, they are choosing to use walk-in clinics."⁷⁶⁴ Many of these clinics are located in pharmacies, retail chains, or supermarkets, allowing consumers quick, convenient, less-costly care.⁷⁶⁵ Do-it-yourself health care is also a trend, with increasingly more people taking responsibility for their health care. Consumers are using smart phone apps to monitor vital signs, medication adherence, and even urinalysis.⁷⁶⁶ As part of a commitment to continuous improvement, VHA will need to consider alternative venues as it creates integrated health care networks.

Medical Technology

Medical technology companies create life-changing innovation, and "advanced medical devices and diagnostics allow people to live longer, healthier and more productive lives."⁷⁶⁷ In fact, during the past 30 years, medical advancements helped add five years to U.S. life expectancy and reduce fatalities from heart disease, stroke, and breast cancer by more than half.⁷⁶⁸ These advancements also yield savings across the health care system by replacing more expensive procedures, reducing hospital stays, and allowing people to return to work more quickly.⁷⁶⁹ Ensuring veterans receive care that employs cutting-edge technology will be an important part of establishing integrated care networks.

Telemedicine

According to the American Telemedicine Association, "telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status."⁷⁷⁰ Telemedicine includes a growing variety of applications and

⁷⁶² Mehul V. Raval et al., "The Importance of Assessing Both Inpatient and Outpatient Surgical Quality," *Annals of Surgery*, 253, 3, (2011): 611-618, accessed June 20, 2016, <http://www.ncbi.nlm.nih.gov/pubmed/21183845>.

⁷⁶³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁶⁴ "Health Care Trends in 2016 Impact Patients While Seeking to More Efficiently Deliver Care," Jinger Jarrett, accessed May 2, 2016, <http://www.inquisitr.com/2710622/healthcare-trends-in-2016-impact-patients-while-seeking-to-more-efficiently-deliver-care/>.

⁷⁶⁵ Ibid.

⁷⁶⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

⁷⁶⁷ "Value of Medical Technology," Advanced Medical Technology Association, accessed May 2, 2016, <http://advamed.org/page/74/value-in-medical-technology>.

⁷⁶⁸ "Value of Medical Innovation," HealthCare Institute of New Jersey, accessed May 2, 2016, <http://hinj.org/value-of-medical-innovation/>.

⁷⁶⁹ Ibid.

⁷⁷⁰ "What is Telemedicine," American Telemedicine Association, accessed May 2, 2016, <http://www.americantelemed.org/about-telemedicine/what-is-telemedicine#.VwFrqfkrJaQ>.

COMMISSION ON CARE FINAL REPORT

services using two-way video, email, smart phones, wireless tools, and other forms of telecommunications technology. The use of telemedicine has spread rapidly and is now becoming integrated into hospitals, specialty departments, home health agencies, private physician offices, as well as consumers' homes and workplaces. The following are examples of how telehealth is being used:

- A specialist assisting the primary care physician in rendering a diagnosis might use interactive video or store-and-forward transmission of diagnostic images or information.
- Home-use devices might be used to remotely collect information such as vital signs, blood glucose, or heart electrocardiogram data and transfer it in real time to a home health agency or a remote diagnostic testing facility for interpretation.
- Consumers' internet and wireless devices might be used to obtain specialized health information or participate in online peer-to-peer support groups.

VHA already excels in the use of telehealth and should expand upon its work in this area.

Midlevel Practitioners

During the past few decades, new categories of health care professionals have become increasingly commonplace in hospital settings. For example, hospitalists, physicians who specialize in the practice of hospital medicine, take over when the community-based physician admits his/her patient to the hospital.⁷⁷¹ The hospitalist does not perform the surgery but rather takes on the monitoring of the hospital services needed by the patient. Another example is medical technicians, who monitor the specialized medical equipment and devices that previously were under the purview of nurses in specialty units such as intensive care units. The growing physician shortage has led to reliance on mid-level health care providers. According to the Centers for Medicare and Medicaid Services' National Provider Identifier dataset, there were approximately 106,000 practicing nurse practitioners and 70,000 practicing physician assistants in 2010.⁷⁷² Provider trends may play into ways VHA can address its current staffing shortage.

Electronic Patient Health Information

Health records have undergone transformation from free-form physician notes of the 17th century to electronic health records (EHRs) of the 21st century. Today, providers are using clinical applications such as computerized physician order entry systems; EHRs; and radiology, pharmacy, and laboratory systems to track patient care and progress. Health plans are providing access to claims and care management, as well as member self-service applications.⁷⁷³ These advances allow the medical workforce to be more mobile and efficient (i.e., physicians can check patient records and test results from wherever they are). Though their use comes with

⁷⁷¹ "Definition of a Hospitalist and Hospital Medicine," Society of Hospital Medicine, accessed May 2, 2016, http://www.hospitalmedicine.org/Web/About_SHM/Hospitalist_Definition/Web/About_SHM/Industry/Hospital_Medicine_Hospital_Definition.aspx.

⁷⁷² "The Number of Nurse Practitioners and Physician Assistants Practicing Primary Care in the United States," Agency for Healthcare Research and Quality, accessed May 2, 2016, <http://www.ahrq.gov/research/findings/factsheets/primary/pcwork2/index.html>.

⁷⁷³ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

inherent potential security and privacy risks, they will surely play a substantial role in shaping future health care.⁷⁷⁴ Interoperability of these sources of patient information will be a continuing key issue in private-sector, military, and veterans' healthcare organizations.

Population Health

Population health refers to considering incidence and prevalence of diseases in a given area to determine if the area or the environment is contributing to the illness. Physicians and other health care providers may look at a region's demographics to determine what types of care are needed within the population. For example, if 65 percent of the region is older than age 65, then a series of wellness programs that address the chronic care concerns of this population may be needed. From a population health perspective, communities and their respective populations are as important as the individual patients who comprise them when it comes to keeping residents healthy. For VHA, population health issues may revolve around populations of veterans who served in particular wars and operations and the respective injuries and illnesses associated with them.

Geriatric Care

In the United States and Western Europe the birth rate has slowed⁷⁷⁵ and people are living longer.⁷⁷⁶ Demographic researchers report that if an American makes it to age 65, he/she should have about 17 to 20 additional years of life.⁷⁷⁷ Nursing homes and assisted living facilities are now seeing increasingly more of residents' first-time admissions occurring at age 80 or older. Some congregate care retirement facilities report that even with admission in the 80s, the average life expectancy is another 12 or 13 years.⁷⁷⁸ The aging population accounts for increasingly more hospital admissions, and as a result, hospitals rely on more revenue from Medicare.⁷⁷⁹ The VHA beneficiary population mirrors the general U.S. population, and older veterans receiving care through VHA may be sicker than their private-sector counterparts.

Chronic Disease Care

Chronic conditions now account for more than 50 percent of the death rate. Acute problems had previously been the primary causes of death.⁷⁸⁰ Even HIV/AIDS has moved away from being considered an immediate death sentence, and now, with proper treatment, is considered by

⁷⁷⁴ "Summary of the HIPAA Privacy Rule," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/>.

⁷⁷⁵ "Fact Sheet: The Decline in U.S. Fertility," Mark Mather, accessed May 2, 2016, <http://www.prb.org/publications/datasheets/2012/world-population-data-sheet/fact-sheet-us-population.aspx>.

⁷⁷⁶ National Center for Health Statistics, *Health, United States, 2015: With Special Feature on Racial and Ethnic Health Disparities*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/abus15.pdf>.

⁷⁷⁷ National Center for Health Statistics, *Life Expectancy at Birth, at Age 65, and at Age 75, by Sex, Race, and Hispanic Origin: United States, Selected Years 1900-2010*, accessed May 2, 2016, <http://www.cdc.gov/nchs/data/abus/2011/022.pdf>.

⁷⁷⁸ Kathleen Harris, *CCRC Resident Demographics and Health Care Utilization: An Analysis*, accessed May 3, 2016, <http://www.avpowell.com/docs/Fall1997.pdf>.

⁷⁷⁹ "The Strategy That Will Fix Health Care," Michael E. Porter and Thomas H. Lee, MD, accessed May 2, 2016, <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>.

⁷⁸⁰ "Chronic Disease Overview," Centers for Disease Control and Prevention, accessed May 2, 2016, <http://www.cdc.gov/chronicdisease/overview/>.

COMMISSION ON CARE FINAL REPORT

most to be a chronic disease.⁷⁸¹ The Centers for Disease Control reports that since 2014, more Americans are dying as a result of chronic conditions and diseases than from acute diseases. Most chronic diseases result from lifestyle choices. Lifestyle diseases result from choices that individuals make.⁷⁸² Health care systems invest resources in addressing lifestyle-related issues caused by behaviors such as smoking, using opiates, and overeating.⁷⁸³ Lifestyle diseases such as cancer caused by smoking, addiction caused by drug use, and diabetes caused by obesity, are costly to treat.⁷⁸⁴ Because lifestyle diseases change over time, they are important to consider in thinking about the future of veterans' healthcare. Treating chronic diseases can be costly because care is ongoing, and assuming this trend continues to become more prominent, it will affect the cost of care and how it is provided.⁷⁸⁵

Needs-based Health Care

The Affordable Care Act requires all not-for-profit hospitals to complete a survey of the community (community health needs assessment, or CHNA) to show what entities in the community will address identified needs (asset mapping) and then report on how the hospital will address these needs in a community health care implementation program (CHIP).⁷⁸⁶ Starting in 2016, hospitals must post these reports on their websites and conduct these evaluations every 3 years thereafter. Monitoring community health needs can lead to preventing or stopping the spread of disease. For example, scarcity of quality food has been documented to result in poor school attendance and increased illness.⁷⁸⁷ Some Americans simply have not been exposed to how to prepare vegetables and fruits because they live in areas that are called *food deserts*, where healthy foods are not readily available. Identifying such needs and how they will be addressed can help improve health for specific populations.⁷⁸⁸ In Washington, DC, such a health assessment led to new treatments and protocols for addressing the appearance of a rare strain of tuberculosis brought in by a group of legal immigrants.⁷⁸⁹ Using CHNA and CHIP could be part of VHA's ongoing planning process.

⁷⁸¹ Steven G. Deeks, Sharon R. Lewin, and Diane V. Havlir, "The End of AIDS: HIV Infection as a Chronic Disease," *Lancet*, 382, 9903, (2013): 1525-1533.

⁷⁸² "Lifestyle Choices: Root Causes of Chronic Diseases," Cleveland Clinic, accessed May 2, 2016, https://my.clevelandclinic.org/health/transcripts/1444_lifestyle-choices-root-causes-of-chronic-diseases.

⁷⁸³ D. B. Resnik, "Responsibility for Health: Personal, Social, and Environmental," *Journal of Medical Ethics*, 33, 8, (2007): 444-445.

⁷⁸⁴ "How to Save a Trillion Dollars," Mark Bittman, accessed May 2, 2016, <http://opinionator.blogs.nytimes.com/2011/04/12/how-to-save-a-trillion-dollars/>.

⁷⁸⁵ "Why We Need Public Health to Improve Healthcare," National Association of Chronic Disease Directors, accessed May 2, 2016, <http://www.chronicdisease.org/?page=WhyWeNeedPH2impHC>.

⁷⁸⁶ "New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act," Internal Revenue Service, accessed May 2, 2016, <https://www.irs.gov/Charities-&-Non-Profits/Charitable-Organizations/New-Requirements-for-501%28c%29%283%29-Hospitals-Under-the-Affordable-Care-Act>.

⁷⁸⁷ "Hunger In Our Schools: Breakfast Is A Crucial 'School Supply' For Kids In Need," Tom Nelson, accessed May 2, 2016, <http://blogs.usda.gov/2015/03/03/hunger-in-our-schools-breakfast-is-a-crucial-school-supply-for-kids-in-need/>.

⁷⁸⁸ "The Capital's Food Deserts," Jeremy Moorhead, accessed May 3, 2016, <http://eatocracy.cnn.com/2012/03/14/the-capitals-food-deserts/>.

⁷⁸⁹ District of Columbia Department of Health HIV/AIDS, Hepatitis, STD, and TB Administration, *District of Columbia HIV/AIDS, Hepatitis, STD, and TB (HAHSTA) Annual Report: 2010*, accessed May 3, 2016, http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2010_Annual_Report_FINAL_0_0.pdf.

Behavioral Health

Treatment for mental health, now more commonly referred to as behavioral health, has changed dramatically since a 1968 federal law required individuals be cared for in the least restrictive environment.⁷⁹⁰ This law led to an expectation that most patients would receive care in out-patient facilities. Recently legislation was passed that requires insurance companies to increase the amount of payment for behavioral health, which could add more patients to the health care system.⁷⁹¹ VHA is a leader in mental health treatment and should continue to be a trendsetter in this regard.

Preventive Medicine

Traditionally, physicians were trained to cure illness and to restore the sick to health. The trend, however, is changing, and physicians are now trained in prevention and are more active participants in the prevention of illness.⁷⁹² Additionally, insurance and Medicare now cover preventive care and annual physicals, further supporting prevention.⁷⁹³ Preventive medicine is a key component of integrated health care and will need to be considered as VHA works to transform veterans' healthcare.

Pharmacy Changes

Health Affairs reports that "in 2015 . . . an alarming trend of new high-cost specialty pharmaceuticals entered the market. . . . Overall drug spending increased 12.2 percent last year, the highest rate of increase in more than a decade."⁷⁹⁴ Escalating drug prices account for some of this increase, including more than 3,500 generic drugs that at least doubled in price from 2008–2015 and about 400 drugs that increased in cost 1000 percent.⁷⁹⁵ Newly emerging and very expensive developments in the area of genomic medication also contribute to the increase. "One way to combat skyrocketing prices will be biosimilar drugs. These drugs are near substitutes for original brand drugs and could bring significant price discounts."⁷⁹⁶ Because many of VHA's beneficiaries seek only prescription benefits, prescription drug trends will be important to consider in the transformation process.

⁷⁹⁰ "How Release of Mental Patients Began," Richard Lyons, accessed May 2, 2016,

<http://www.nytimes.com/1984/10/30/science/how-release-of-mental-patients-began.html?pagewanted=all>.

⁷⁹¹ "Implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA)," Substance Abuse and Mental Health Services Administration, accessed May 2, 2016, <http://www.samhsa.gov/health-financing/implementation-mental-health-parity-addiction-equity-act>.

⁷⁹² "Opinion 8.075 – Health Promotion and Preventive Care," American Medical Association, accessed May 2, 2016, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion8075.page>.

⁷⁹³ "Preventive Services Covered Under the Affordable Care Act," U.S. Department of Health and Human Services, accessed May 2, 2016, <http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/>.

⁷⁹⁴ Anne Martin et al., "National Health Spending In 2014: Faster Growth Driven By Coverage Expansion And Prescription Drug Spending," *Health Affairs*, 35, 1, (2016): 150-160.

⁷⁹⁵ "Generic Drug Prices Quickly on the Rise," Anthony L. Komaroff, accessed May 2, 2016, <http://www.spokesman.com/stories/2016/feb/18/generic-drug-prices-quickly-on-the-rise/>.

⁷⁹⁶ "Top Health Industry Issues of 2016: Thriving in a New Health Economy," PwC, accessed May 2, 2016, <https://www.pwc.com/us/en/health-industries/top-health-industry-issues/assets/2016-us-hri-top-issues.pdf>.

COMMISSION ON CARE FINAL REPORT

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX F:

THE COMMISSION'S PROCESS

Commission Meetings

From September 2015 to June 2016, the Commission held convened 12 sessions of public meetings (26 days). The content addressed at each meeting is listed in the following table.

September 21-22, 2015

Assessment A: Demographics	RAND Corporation <ul style="list-style-type: none"> Christine Eibner
Assessment B: Health Care Capabilities	RAND Corporation <ul style="list-style-type: none"> Peter Hussey, PhD
VA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> Bob McDonald, Secretary Sloan Gibson, Deputy Secretary David Shulkin, MD, Under Secretary for Health
Assessment C: Care Authorities	RAND Corporation <ul style="list-style-type: none"> Michael D. Greenberg
Assessment I: Business Processes	Grant Thornton LLP <ul style="list-style-type: none"> Lane Jackson Aamir Syed Sharif Ambrose
Assessment E: Scheduling Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Alex Harris Pooja Kumar
Assessment F: Clinical Workflow	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Gretchen Berlin
Assessment G: Staffing/Productivity/Time Allocation	Grant Thornton LLP <ul style="list-style-type: none"> Peter Erwin, PhD Hillary Peabody Erik Shannon
Assessment J: Supplies	McKinsey & Company <ul style="list-style-type: none"> Kurt Grote, MD Robin Roark, MD
Assessment K: Facilities	McKinsey & Company <ul style="list-style-type: none"> Vivian Riefberg John Means

COMMISSION ON CARE FINAL REPORT

September 21-22, 2015 (continued)

VHA Leadership	Department of Veterans Affairs <ul style="list-style-type: none"> ▪ Patricia Vandenberg, Assistant Deputy Under Secretary for Health for Policy and Planning
Assessment Leadership	CMS Alliance to Modernize Health care <ul style="list-style-type: none"> ▪ Stephen Kirin ▪ Jay Schnitzer, PhD, MD McKinsey & Company <ul style="list-style-type: none"> ▪ Vivian Riefberg
Assessment H: Health IT	MITRE Corporation <ul style="list-style-type: none"> ▪ Aparna Durvasula ▪ Glenn Himes McKinsey & Company <ul style="list-style-type: none"> ▪ Celia Huber ▪ Vivian Riefberg

October 6, 2015

Eligibility	Veterans Health Administration <ul style="list-style-type: none"> ▪ Stephanie Mardon, Chief Business Officer ▪ Kristin Cunningham, Director, Business Policy Affairs
2014 Choice Act/2015 Enhancement to Choice/Care in the Community, Current State	Veterans Health Administration <ul style="list-style-type: none"> ▪ Stephanie Mardon, Chief Business Officer ▪ Kristin Cunningham, Director, Business Policy Affairs
Future State of VA Community Care/ Care in the Community	Veterans Health Administration <ul style="list-style-type: none"> ▪ Joe Dalpiaz, Director, VISN 17 ▪ Baligh Yehia, MD, Senior Health Advisor to the Secretary of Veterans Affairs ▪ Gene Migliaccio, Deputy Chief Business Officer, Managed Care
Academic Affiliations	Veterans Health Administration <ul style="list-style-type: none"> ▪ Robert Jesse, MD, Chief, Office of Academic Affiliations ▪ Karen Sanders, MD, Deputy Chief, Office of Academic Affiliation Long-Term Care ▪ Richard Allman, MD, Chief Consultant, Geriatrics and Extended Care Services

October 19–20, 2015

Independent Assessment, Perspective on VA Health Care, and Q&A/Panel Discussion	<ul style="list-style-type: none"> ▪ Brett Giroir, MD, Senior Fellow, Health Policy Institute, Texas Medical Center ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE ▪ Jonathan Perlin, MD, Chief Medical Officer and President, Clinical Services at Hospital Corporation of America
Women's Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ Patricia Hayes, PhD, Chief Consultant, VA Women's Health Services
Mental Health	Veterans Health Administration <ul style="list-style-type: none"> ▪ David Carroll, Executive Director, Mental Health Operations ▪ Harold Kudler, MD, Chief Mental Health Consultant
Homelessness	Veterans Health Administration <ul style="list-style-type: none"> ▪ Anne Dunn, Deputy Director, VHA Homeless Program Office
Assessment D: Access	Institute of Medicine <ul style="list-style-type: none"> ▪ Michael McGinnis, MD ▪ Marianne Hamilton Lopez
VACAA Section 203	Northern Virginia Technology Council <ul style="list-style-type: none"> ▪ Ken Mullins
Scheduling	Veterans Health Administration <ul style="list-style-type: none"> ▪ Michael Davies, MD, Executive Director of Access and Clinic Administration Program
MyVA Support Services Excellence Overview	Department of Veterans Affairs <ul style="list-style-type: none"> ▪ Bob Snyder, Executive Director, MyVA Task Force ▪ Tom Muir, Director, Support Services

November 16–17, 2015

Health Care Economics/Finance	<ul style="list-style-type: none"> ▪ Mark Yow, Acting Chief Financial Officer, VHA ▪ Paul Mango, McKinsey & Company ▪ Gail Wilensky, PhD, Senior Fellow at Project HOPE
Academic Affiliations	Association of American Medical Colleges <ul style="list-style-type: none"> ▪ Atul Grover, PhD, MD, Chief Public Policy Officer ▪ John E. Prescott, MD, Chief Affiliations Officer ▪ Matthew Schick, JD, Director, Government Regulations & Regulatory Counsel
VHA Clinical Matters	Veterans Health Administration <ul style="list-style-type: none"> ▪ Lucille Beck, PhD, Deputy Chief Patient Care Services Officer, Rehab and Prosthetic Services ▪ Donna Gage, PhD, RN, Chief Nursing Officer

COMMISSION ON CARE FINAL REPORT

December 14-16, 2015

Minority Affairs and Health Equity	Department of Veterans Affairs <ul style="list-style-type: none"> Barbara Ward, Director, Center for Minority Affairs Veterans Health Administration <ul style="list-style-type: none"> Uchenna S. Uchendu, MD, Executive Director, Office of Health Equity
Framework for the Future of Veterans Health	<ul style="list-style-type: none"> Garry Augustine, Disabled American Veterans Carl Blake, Paralyzed Veterans of America Carlos Fuentes, Veterans of Foreign Wars Ray Kelley, Veterans of Foreign Wars
Veteran Service Organizations	<ul style="list-style-type: none"> Louis Celli, The American Legion Renee Campos, Military Officers Association of America
National Health Information Operability	<ul style="list-style-type: none"> Dr. Jon White, Deputy National Coordinator, Department of Health and Human Services
DoD I Procurement: Lesson Learned/Interagency Program Office	<ul style="list-style-type: none"> Chris Miller, Program Executive Officer, Defense Health Care Management Systems, Department of Defense
Health Information Exchange	<ul style="list-style-type: none"> Elaine Hunolt, Do-Director Interoperability Office, Veterans Health Administration Dr. Harry Leider, Chief Medical Officer, Walgreens James Wood, VP-Federal, Walgreens Mariann Yeager, Chief Executive Officer, The Sequoia Project
Vision for OI&T/Collaboration with VHA	<ul style="list-style-type: none"> LaVerne Council, Chief Information Officer, Department of Veterans Affairs
Leadership and Transformation	<ul style="list-style-type: none"> Charles Rossotti, Former Commissioner, Internal Revenue Service

January 19 and 21, 2016

VHA Leadership	<ul style="list-style-type: none"> Dr. Michael Kussman, former Undersecretary for Health, Veterans Health Administration Dr. Kenneth Kizer, former Undersecretary for Health, Veterans Health Administration
Labor Perspectives	American Federal of Government Employees <ul style="list-style-type: none"> Marilyn Park National Association of Veterans Affairs Physicians and Dentists <ul style="list-style-type: none"> Samuel Spagnolo Nurses Organization of Veterans Affairs <ul style="list-style-type: none"> Joan Clifford Sharon Johnson

January 19 and 21, 2016 (continued)

Behavioral Health	<ul style="list-style-type: none"> Association of Veterans Affairs Psychologist Leaders <ul style="list-style-type: none"> Thomas Kirchberg Russell Lemle Edgardo Padin-Rivera Antonette Zeiss American Psychiatric Association <ul style="list-style-type: none"> Jenny L. Boyer Association of Veterans Affairs Social Workers <ul style="list-style-type: none"> LeAnn Bruce Jerry Satterwhite
Homeless Veterans	<ul style="list-style-type: none"> Keith Armstrong, San Francisco Veterans Affairs Health care System
Other-Than-Honorable Discharges	<ul style="list-style-type: none"> Branford Adams

February 8-9, 2016

Construction Management	<ul style="list-style-type: none"> Lisa Freeman, Medical Center Director, Palo Alto Health care System
VISN and Field Leadership Perspectives	<ul style="list-style-type: none"> Joleen Clark, Former Network Director, VISN 8 Jon Gardner, Former Medical Center Director, Tucson VA Medical Center Lisa Freeman, Medical Center Director, Palo Alto Health care System
Implementation of the <i>Choice Program</i>	<ul style="list-style-type: none"> Billy Maynard, President HealthNet Federal Service David J. McIntyre, Jr., President and Chief Executive Officer, TriWest Healthcare Alliance
Update on VHA	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health, Veterans Health Administration
Determining Feasibility	<ul style="list-style-type: none"> Patrick Ryan, Former Staff Director and Chief Counsel, House Veterans Affairs Committee

February 29 – March 1, 2016

Economist Briefing	<ul style="list-style-type: none"> Gideon Lukens, PhD, Staff Economist Jamie Taber, PhD, Staff Economist
--------------------	--

March 21-23, 2016

Conversation with HVAC Chairman	<ul style="list-style-type: none"> Rep. Jeff Miller (R-FL)
Conversation with HVAC Member	<ul style="list-style-type: none"> Rep. Beto O'Rourke (D-TX)
Veterans Health Administration	<ul style="list-style-type: none"> Dr. David Shulkin, Undersecretary for Health Barbara Manning, Office of Policy and Planning Lyn Stoesen, Office of Policy and Planning

COMMISSION ON CARE FINAL REPORT

March 21-23, 2016 (continued)

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Merideth Randles, FSA, MAAA, Milliman, Inc.
- Jamie Taber, PhD, Staff Economist

April 18-19, 2016

Veterans Service Organizations

- Garry Augustine, Disabled American Veterans
- Peter Dickinson, Disabled American Veterans
- Verna Jones, American Legion
- Rick Weidman, Vietnam Veterans of America
- Bill Rausch, Got Your 6
- Ray Kelley, Veterans of Foreign Wars
- Rene Campos, Military Officers Association of America

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

VA Leadership

Department of Veterans Affairs

- Bob McDonald, Secretary
- Sloan Gibson, Deputy Secretary

Community Care

- Baligh Yehia, MD, Assistant Deputy Under Secretary for Community Care, VHA

May 9-11, 2016

VA Office of General Counsel

- Leigh Bradley, General Counsel
- Jessica Tanner, Staff Attorney

Economist Briefing

- Gideon Lukens, PhD, Staff Economist
- Jamie Taber, PhD, Staff Economist

June 7-8, 2016

No speakers

Commission Workgroups

The Commission on Care organized itself into workgroups in order to complete an analysis of relevant issues, consider options, and suggest recommendations to the full Commission for debate. The Commission formed five workgroups with each responsible for sections of the Independent Assessment or other topics taken on by the group. In establishing each workgroup an effort was made to balance perspectives and expertise, although Commissioners expressed interests were also taken into account in forming the membership of each group. The membership of each workgroup and the topics taken on by each is summarized in Table F-1.

Table F-1. Workgroup Structure and Topics

WORKGROUP NAME	TOPICS	MEMBERSHIP	
Health Care Alignment	<ul style="list-style-type: none"> ▪ Demographics ▪ Health care Capabilities ▪ Care Authorities ▪ Access Standards ▪ Governance 	<ul style="list-style-type: none"> ▪ Blecker ▪ Johnson ▪ Longman ▪ Selnick 	<ul style="list-style-type: none"> ▪ Gorman ▪ Khan ▪ McClenney
Health Care Operations	<ul style="list-style-type: none"> ▪ Access Standards ▪ Workflow Scheduling ▪ Workflow Clinical ▪ Staffing Productivity 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Harvey ▪ Longman ▪ Webster 	<ul style="list-style-type: none"> ▪ Gorman ▪ Hickey ▪ Taylor
Health Care Data, Tools & Infrastructure	<ul style="list-style-type: none"> ▪ Health IT ▪ Business Processes ▪ Supplies ▪ Facilities 	<ul style="list-style-type: none"> ▪ Blom ▪ Harvey ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Johnson ▪ Taylor
Health Care Leadership	<ul style="list-style-type: none"> ▪ Organizational Health ▪ Leadership Systems 	<ul style="list-style-type: none"> ▪ Blecker ▪ Hickey ▪ Selnick ▪ Steele 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ McClenney ▪ Schlichting
Health Care Trends	<ul style="list-style-type: none"> ▪ Market Trends ▪ Technology ▪ Financing ▪ Vision 	<ul style="list-style-type: none"> ▪ Blom ▪ Johnson ▪ Schlichting 	<ul style="list-style-type: none"> ▪ Cosgrove ▪ Khan ▪ Webster

Each workgroup, together with any staff assigned to it, reviewed the findings and recommendations of the Independent Assessment and the Integrated Report; investigated external benchmarks and best practice models; heard testimony in public meetings (with the full Commission); met in workgroup session with VA employees, leaders, former staff and external experts to gather additional insights and explore relevant questions. Commissioners reviewed white papers and strawman proposals prepared by staff and by one another. Based on the assessments and group deliberations, each workgroup developed recommendations for consideration by the full Commission. Details of the process and outputs from each workgroup are described in the following sections.

COMMISSION ON CARE FINAL REPORT

Health Care Alignment Workgroup

The alignment workgroup organized its work around six main topics: governance, realignment of facilities and services, medical sharing, eligibility, other than honorable discharges, and the organization of provider networks. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic was introduced through a summary paper or summary points which then were used as the basis for a conference call or a face-to-face discussion. For most topics, subsequent calls were held to discuss more detailed papers or to re-visit outstanding issues not yet resolved.

Commissioners also reviewed draft papers and provided additional feedback, revisions, and comments through written comments. The papers were finalized for inclusion in the draft Commission report for discussion on April 19. A summary of the work completed on each topic is provided in the table below.

Table F-2. Alignment Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Governance	11/17/2015	M	Vivian Riefberg	9/22/2015	F
	1/7/2016	C	Stephen Kirin	9/22/2015	F
	1/28/2016	C	Jay Schnitzer	9/22/2015	F
	2/18/2016	C	Paul Light	10/30/2015	S
	3/3/2016	C	Charles Rossotti	12/16/2015	F
	3/10/2016	C	Michael Kussman	1/19/2016	F
	3/17/2016	C	Ken Kizer	1/19/2016	F
	4/7/2016	C	Jeff Miller	3/21/2016	F
Realignment of Facilities and Services	1/7/2016	C	Vivian Riefberg	9/22/2015	F
	1/28/2016	C	John Means	9/22/2015	F
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Medical Sharing	1/28/2016	C	Atul Gover	11/16/2015	F
	3/3/2016	C	John Prescott	11/16/2015	F
	3/10/2016	C	Mathew Schick	11/16/2015	F
	3/17/2016	C			
	4/7/2016	C			
Eligibility	11/17/2015	M	Christine Eibner	9/21/2015	F
	12/10/2015	C	Michael Greenberg	9/21/2015	F
	1/28/2016	C	Pat Vandenberg	9/21/2015	F
	2/25/2016	C	Stephenie Mardon	10/6/2015	F
	3/10/2016	C	Kristin Cunningham	10/6/2015	F
	3/17/2016	C	Gail Wilensky	10/19/2015	F
	4/7/2016	C	Michael McGinnis	10/20/2015	F
			Marianne Hamilton Lopez	10/20/2015	F
			Michael Kussman	1/19/2016	F
			Jeff Miller	3/21/2106	F

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E=email review M=face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Other-Than-Honorable Discharge	1/28/2016	C	Bradford Adams	1/20/2016	F
	2/18/2016	C			
	3/10/2016	C			
	3/17/2016	C			
	4/7/2016	C			
Organization of Provider Networks	1/28/2016	C	Peter Hussey	9/21/2015	F
	2/25/2016	C	Joe Dalpiaz	10/6/2015	F
	3/10/2016	C	Baligh Yehia	10/6/2015	F
	3/17/2016	C	Gene Migliaccio	10/6/2015	F
	4/7/2016	C	Michael Kussman	1/19/2016	F
			Jon Gardner	2/8/2016	F
			Billy Maynard	2/8/2016	F
			David McIntrye	2/8/2016	F
			Jeff Miller	3/21/2016	F
			Beto O'Rourke	3/22/2016	F

Health Care Operations Workgroup

The health care operations workgroup was organized around five main topics: access standards, scheduling, clinical workflow, staffing (HR), and productivity. The workgroup (select Commissioners and support staff) first met face-to-face on October 7, 2015 to: introduce the staff, review guiding principles and business rules, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics was discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research on the four main topics; and cover other issues that may have come up during sessions (i.e., Best Practices) or from questions posed by Commissioners. To supplement the Commission conferences, the workgroup held teleconferences to cover additional research or present information from subject matter experts or emailed informational briefs and write-ups for review before a workgroup teleconference. Feedback from the Commissioners was addressed and the potential recommendations were refined. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

COMMISSION ON CARE FINAL REPORT

Table F-3. Health Care Operations Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Access Standards	10/20/2015	M	Stephanie Mardon	10/6/2015	F
	12/3/2015	C	Kristin Cunningham	10/6/2015	F
	2/25/2016	C	Institute of Medicine	10/13/2015	S
	4/27/2016	C	Institute of Medicine	10/20/2015	F
Scheduling	10/7/2015	M	McKinsey Co	9/22/2015	F
			Stephanie Mardon	10/6/2015	F
			Kristin Cunningham	10/6/2015	F
			Dr. Michael Davies	10/14/2015	S
			Gary Monder	10/14/2015	S
			Steve Green	10/14/2015	S
			Michael McGinnis	10/14/2015	S
			Ken Mullins	10/14/2015	S
			Marianne Hamilton Lopez	10/14/2015	S
			Institute of Medicine	10/20/2015	F
			Dr. Michael Davies	10/20/2015	F
			Dr. Michael Davies	11/18/2015	W
Clinical Workflow	10/27/2015	C	McKinsey & Co.	9/22/2015	F
	2/18/2016	C	Nora Socci	12/29/2015	S
	4/6/2016	C	Diane Pulphus	2/3/2016	S
			Hugh Scott	2/26/2016	S
Staffing	11/4/2015	C	McKinsey Co	9/22/2015	F
	12/3/2015	C	Dr. Jonathan Perlin	10/19/2015	F
	1/20/2016	M	Barbara Ward	12/7/2015	S
	2/18/2016	C			
	2/25/2016	C			
	4/6/2016	C			
Productivity	12/15/2015	M	McKinsey Co	9/22/2015	F
			Gene Migliaccio	10/6/2015	F
			Boston VAMC	12/7/2015:	S
			Dr. Michael Charness		
			Melanie Gilhern		
			Meredith Walker		
Best Practices	1/6/2016	C	Dr. Melanie Vielhauer		
			Rosemary Conlon		
	1/20/2016	M	McKinsey Co	9/22/2015	F
	2/25/2016	C	Dr. Theresa Cullen	12/2/2015	W
	3/14/2016	E	Dr. Daniel Bochicchio	12/3/2015	S
			David Atkins	1/5/2016	S
			Linda Lipson	1/5/2016	S
			Amy Kilbourne	1/5/2016	S
			Bob Monte	1/5/2016	S
			Rachel Goffman	1/5/2016	S
			Dr. Daniel Bochicchio	1/20/2016	S
			Barbara Meadows	2/25/2016	W
			Barbara Meadows	3/17/2016	W

Health Care Data, Tools & Infrastructure Workgroup

The Health Care Data, Tools & Infrastructure (DTI) workgroup organized its work around four main topics: Health Information Technology, Business Processes, Supplies and Facilities. DTI first met face to face on October 7, 2015 to: introduce the staff, review the charge of DTI, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each of the main topics were discussed. During the larger public sessions the Commissioners and staff heard directly from Veterans Affairs staff or outside experts to inform future deliberations. In follow-on meetings the workgroup continued to present research via white papers on the four main topics; and cover other issues that may have come up during sessions or from questions posed by Commissioners. To supplement the Commission face-to-face meetings, the workgroup held teleconferences to cover additional research or present information from subject matter experts. Feedback from the Commissioners was incorporated into the white papers and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. These papers were finalized and readied for presentation to the full Commission for deliberation and feedback. A summary of the work completed on each topic is provided in the table below.

Table F-4. Data, Tools & Infrastructure Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call		S=met with staff		
	E= email review		W=met with workgroup		
	M= face-to-face meeting		F=full Commission testimony		
	Date	Type	Expert	Date	Type
Health IT	10/7/2015	M	MITRE Co	9/22/2015	F
	11/18/2015	C	Dr. Brett Giroir	10/19/2015	S
	12/2/2015	C	LaVerne Council,	10/27/15	HVAC
	3/7/2016	C	Chris Miller, Brian Burns		Hearing
	3/14/2016	C	Brookings Institution	11/6/2015	S
	3/21/2016	M	LaVerne Council	11/25/2015	S
	4/4/2016	C & E	Dr. Theresa Cullen	12/2/2015	W
			Chris Miller	12/15/2015	F
			Chuck Hume	12/15/2015	F
			Elaine Hunolt	12/15/2015	F
			Jim Wood	12/15/2015	F
			Mariam Yeager	12/15/2015	F
			LaVerne Council	12/15/2015	F
			Jamie Bennett	3/2/2016	S
			Margaret Donahue	3/11/2016	S
			Kai Miller	4/12/2016	S
Business Processes	10/20/2015	M	SecVA Bob McDonald	9/21/2015	F
	10/26/2015	M			
	3/14/2016	C			
	3/21/2016	M			
	4/4/2016	C			

COMMISSION ON CARE FINAL REPORT

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting	Date	Expert	Date	Type
Supplies (Pharmaceutical & Medical Devices)	10/7/2015	M	McKinsey Co	9/21/2015	F
	10/26/2015	M	Jonathan Miller	12/4/2015	S
	2/23/2016	E	Tucker Taylor	12/4/2015	S
	2/24/2016	C			
	3/7/2016	C			
	3/14/2016	C			
	3/21/2016	M			
Facilities	10/7/2015	M	Bob McDonald	9/21/2015	F
	11/18/2015	M	Jim Sullivan	11/11/2015	S
	12/2/2015	C	Mark W. Johnson	12/21/2015	S
	12/22/2015	M	Kyle Reinhardt	12/22/2015	S
	2/16/2016	E	Thom Kurmel	12/22/2015	S
	2/17/2016	C	Rick Bond	12/22/2015	S
	2/24/2016	C & E	John Bulick	12/22/2015	S
	3/7/2016	C	John Kay	12/22/2015	S
	3/14/2016	C	Jim Sullivan	2/16/2016	S
	3/21/2016	M	Ed Bradley	2/16/2016	S
	4/4/2016	C	Jim Sullivan	2/17/2016	W
	4/11/2016	C	Jim Sullivan	3/15/2016	S
	4/27/2016	C			
Other	11/5/2015	E			
	11/6/2015	E			
	3/11/2016	E			

Health Care Leadership Workgroup

The leadership workgroup organized its work around five main topics: organizational health and cultural transformation and four leadership system issues: recruitment, retention, development and advancement; organizational structure and function; performance management and performance measurement; and human capital management. The workgroup met in a face-to-face session on October 7, 2015 to review the charge of the workgroup, orient one another to the task envisioned for the group, and decide how the workgroup would function to complete its work. In general, each topic received an evidence review and summary which was the basis for a conference call or a face-to-face discussion. On a few topics, Commissioners or staff heard directly from VA staff or outside experts to inform the deliberation. Then, in a second meeting on the topic, the Commissioners debated a strawman proposal and alternative recommendations based on the evidence review and the prior Commission discussion. Feedback from the Commissioners was incorporated into the strawman and the potential recommendations were refined. Commissioners then reviewed the draft papers derived from this process and provided additional feedback, revisions, and comments through meetings and written comments. The papers were finalized and presented to the full Commission for deliberation and feedback on March 22, 2016. A summary of the work completed on each topic is provided in the table below.

APPENDIX F
THE COMMISSION'S PROCESS

Table F-5. Leadership Workgroup Activities

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Organizational Health and Cultural Transformation	12/2/2015	C	Stephen Kirin	9/23/2015	F
	12/9/2015	C	Jay Schnitzer	9/23/2015	F
	2/9/2016	M	Vivian Riefberg	9/23/2015	F
	2/17/2016	C	Dee Ramsel	11/9/2015	S
	3/11/2016	E	Ashby Sharpe	11/9/2015	S
			Ken Berkowitz	11/9/2015	S
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
Recruitment, Retention, Development, and Advancement	11/17/2015	M	Stephen Kirin	9/23/2015	F
	11/25/2015	C	Jay Schnitzer	9/23/2015	F
	2/17/2016	C	Vivian Riefberg	9/23/2015	F
	2/24/2016	C	Volney Warner	11/9/2015	S
	3/9/2016	C	Lisa Red	11/17/2015	W
	3/11/2016	E	Payton Rica-Lewis	11/17/2015	W
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Georgia Coffey	2/22/2016	S
			David Perry	2/24/2016	S
			Audrey Oatis-Newsome	2/24/2016	S
Organizational Structure and Function	10/27/2015	C	Stephen Kirin	9/23/2015	F
	2/9/2016	M	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Charles Rossotti	12/16/2015	F
			Michael Kussman	1/19/2016	F
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Robin Hemphill	3/4/2016	S
Performance Management and Performance Measurement	11/4/2015	C	Stephen Kirin	9/23/2015	F
	11/12/2015	C	Jay Schnitzer	9/23/2015	F
	2/19/2016	E	Vivian Riefberg	9/23/2015	F
	3/9/2016	C	Jon Perlin	10/20/2015	F
	3/11/2016	E	Peter Almenoff	10/30/2015	S
			Joe Francis	1/8/2016	S
			Carolyn Clancy	1/8/2016	S
			Ken Kizer	1/19/2016	F
			Lisa Freeman	2/8/2016	F
			Joleen Clark	2/8/2016	F
			Jon Gardner	2/8/2016	F
			Noel Baril	3/9/2016	S

COMMISSION ON CARE FINAL REPORT

WORKGROUP TOPIC	WORKGROUP ACTIVITY		EXPERT INPUT		
	C=call E= email review M= face-to-face meeting		S=met with staff W=met with workgroup F=full Commission testimony		
	Date	Type	Expert	Date	Type
Human Capital Management	12/15/2015	M	Stephen Kirin	9/23/2015	F
	12/23/2015	C	Jay Schnitzer	9/23/2015	F
	3/11/2016	E	Vivian Riefberg	9/23/2015	F
			Sam Retherford	12/15/2015	W
			Joleen Clark	2/8/2016	F
Leadership Vision	1/6/2016	C			
	1/21/2016	M			
	2/3/2016	C			
	2/4/2016	E			
Leadership Pre-amble	3/14/2016	E			

Site Visits

Background

In the coming decades there will be increased demand for accountability in health care and increased emphasis on health care outcomes and measurements, and VHA will need to rise to meet these expectations to survive and remain competitive in the demanding and turbulent health care environment.⁷⁹⁷ The changing nature of health care organizations, including pressure to reduce costs, improve the quality of care, and meet stringent guidelines, has forced health care professionals to reexamine how they evaluate performance.⁷⁹⁸ Although many health care organizations have long recognized the need to look beyond financial measures when evaluating performance, many still struggle with what measures to select and how to use the results of those measures.⁷⁹⁹

As the nation's largest health care system in 2016, VHA employs more than 305,000 health care professionals and support staff at more than 1,000 sites of care, including hospitals, community-based outpatient clinics (CBOCs), nursing homes, domiciliaries, and 300 Vet Centers.⁸⁰⁰ Given the scope of this health care system, the Commission recognized the importance of direct lines of communication and interaction with VHA leaders, staff, and patients, to include conducting facility site visits. Commissioners conducted facility site visits to their local VA facilities to assist in the evaluation of the findings identified by the *Independent Assessment Report*, to contribute to an environmental scan of the VHA, and to inform the development of recommendations.⁸⁰¹

Scope of Site Visits

In January and February 2016, most of the 15 Commissioners conducted site visits to the VA medical centers (VAMCs) and CBOCs proximal to their respective residences. The Commissioners approached these site visits with a collaborative and information-seeking tone with the purpose of having open discussions with VAMC leadership, staff, and patients.

Individual Commissioners visited 12 VAMC facilities or CBOCs in 7 out of 19 Veteran Integrated Service Networks (VISNs). Additionally, all the Commissioners who attended the February 29, 2016, meeting in Dallas, TX, toured the Dallas VAMC.

⁷⁹⁷ Kenneth W. Kizer, M.D., M.P.H./Department of Veterans Affairs, *Prescription for Change: The Guiding Principles and Strategic Objectives Underlying the Transformation for the Veterans Healthcare System*, accessed March 1, 2016, <http://www.va.gov/healthpolicyplanning/rxweb.pdf>.

⁷⁹⁸ Kicab Castaneda-Mendez/Quality Digest, *Performance Measurement in Health Care*, accessed, March 1, 2016, <http://www.qualitydigest.com/magazine/1999/may/article/performance-measurement-health-care.html#>.

⁷⁹⁹ Ibid.

⁸⁰⁰ Department of Veterans Affairs, Undersecretary for Health, accessed March 1, 2016, <http://vaww.us.hva.gov/>.

⁸⁰¹ The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, v, accessed March 11, 2016, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

COMMISSION ON CARE FINAL REPORT

Table F-6. VA Facility Site Visit Locations

VISN	VISN Name	VA Facility
2	VISN 2	VA Hudson Valley Health Care System (Montrose, NY)
6	VA Mid-Atlantic Health Care Network	Fredericksburg Community-based Outpatient Center, (Fredericksburg, VA)- part of Hunter Holmes McGuire VA Medical Center, Richmond, VA
7	VA Southeast Network	Ralph H. Johnson VA Medical Center (Charleston, NC) Wm. Jennings Bryan Dorn VA Medical Center (Columbia, SC)
10	VA Health Care System	VA Ann Arbor Health care System (Ann Arbor, MI) John D. Dingell VA Medical Center (Detroit, MI)
17	VA Heart of Texas Health Care System	Dallas VA Medical Center (Dallas, TX)
21	Sierra Pacific Network	Southern Nevada Health care System (Las Vegas, NV) VA Northern California Health Care System (Mather, CA) VA Palo Alto Health Care System (Palo Alto, CA)
22	Desert Pacific Health Care Network	Greater Los Angeles Health care System (Los Angeles, CA) VA San Diego Health care System (San Diego, CA)

The Commissioners were provided with a generic basic agenda as guidance, though they had the latitude to determine their own agendas as appropriate for the locations they visited. The model agenda included the following activities: a welcome and overview of the VA health care facility; tour of the facility; veteran discussion session (informal or formal); VHA employee session (e.g., informal or small group discussion); a discussion with the facility leadership, and were provided the recommended questions listed below:

- What does the medical center do well?
- What unique resources can the medical center draw on?
- What do others see as the strengths of the medical center?
- What could the medical center improve?
- Where does the medical center have fewer resources than others?
- What are others likely to see as weaknesses of medical center?
- What opportunities are open to the medical center?
- What trends could the medical center take advantage of?
- How can the medical center turn its strengths into opportunities?
- What threats could harm the medical center?
- What obstacles does the medical center face?
- What threats do the medical center's weaknesses expose it to?

- What is the impact of MyVA?
- How do employees view working at VA compared to two or three years ago? If there is a change, what is driving it?
- In your view, what is the most important factor affecting patient satisfaction with the care you provide?
- In your view, has there been a change in the perception of the quality of care provided by the medical center? If so, what might be driving this different perception?

Once the Commissioners completed their visits, they provided the data they gathered to Commission staff to be organized in a strengths-weaknesses-opportunities-threats (SWOT) analysis framework. A SWOT analysis is a simple but useful framework for analyzing the four factors as they are faced by an organization. It helps organizations develop strengths, minimize threats, and take the greatest advantage of available opportunities.⁸⁰²

Findings

VHA leadership and staff enthusiastically shared their time, insights, perspective, and data on organizational and operational processes with the Commissioners. The site visits provided insight and reinforced the findings of the *Independent Assessment Report*.

Confirming what the *Independent Assessment Report* stated, the Commissioners found VHA facilities' staff members exhibit a deep commitment to serving veterans, but that VHA's health care facilities deliver strikingly different patient experiences, apply inconsistent business processes, and differ widely on key measures of performance and efficiency.⁸⁰³ Based on Commissioners' observations of weaknesses, challenges, and threats related to daily operations, VAMC staff members appear to be searching for suitable solutions. Anecdotal responses provided to the Commissioners illuminated the following systemic problem areas at the VAMCs:

- Care authorities: health care capabilities (i.e., purchased care)
- Staffing: productivity (i.e., human resources), health care capabilities, access standards, clinical workflow
- Leadership: staffing, productivity (i.e., human resources)
- Facilities: health care authorities (i.e., patient-centered community care)

Data from Commissioners' observation notes were organized into a SWOT analysis chart based on the common themes of the Commissioners' facility site visits. The purpose of this exercise was to gather information to inform the Commission's recommendations and to confirm or

⁸⁰² "SWOT Analysis," Mind Tools, accessed March 15, 2016, https://www.mindtools.com/pages/article/newTMC_05.htm.

⁸⁰³ "Veterans Integrated Service Networks (VISN)," Department of Veterans Affairs, VHA, accessed March 14, 2016, <http://www.va.gov/directory/guide/division.asp?dnum=1>.

COMMISSION ON CARE FINAL REPORT

dispute the findings of the *Independent Assessment Report*. The Commissioner site visit inputs are summarized in the table below.

Table F-7. *SWOT Analysis of Commissioner Site Visit Observations*

Strengths	Weaknesses	Opportunities	Threats
<ul style="list-style-type: none"> ▪ VA medical center workforce customer service and dedication ▪ Research and national databases ▪ Veterans service – connected services and programs ▪ Partnerships with medical schools and training programs 	<ul style="list-style-type: none"> ▪ Inefficient/ineffective HR policies ▪ High levels of staffing vacancies ▪ Lack of clinical space; inefficient configurations of clinical space ▪ Poor access to VA care for rural veterans ▪ Lack of an effective financial system to provide real-time payment process to veterans Choice and Purchased Care Programs ▪ Lack of effective VHA leadership workforce ▪ Lack of capacity/access to appointments in VHA ▪ Insufficient federal government health care appropriation rules 	<ul style="list-style-type: none"> ▪ Modernization of VA IT ▪ Customer service training/standards ▪ Strategic focus on VHA core mission ▪ Local funding flexibility from Congress ▪ New vision and mission for VHA health care ▪ Process/systems reengineering ▪ Recruitment of outside leader candidates and retention of high-performing VHA leaders 	<ul style="list-style-type: none"> ▪ Misalignment between Congress's health care operational plans for veterans and VHA strategic health care plans ▪ Competing stakeholders health care interests ▪ Office of Personnel Management outdated standards/policies ▪ Insufficient VHA leadership development ▪ Insufficient IT funding ▪ The physician shortages around the nation has severely impacted the care of patients

Conclusions

Fundamental transformation of VHA is needed to ensure optimal delivery of veteran-centered, high-quality care. Essential to laying the path to excellence and strategic planning is a comprehensive understanding of the current state as well as the opportunities and threats facing the system. A robust connection between leaders in VHA Central Office and leaders in the field is critical to meet the needs of the veteran population served.

As part of the strategic planning process, VA/VHA leadership should make recurring site visits to VHA facilities, including VAMCs, VISN headquarters, and CBOCs to obtain current insight of the following critical areas: health care trends, health care operations, facility management and renovation/replacement, business processes and contracting, and other trends or issues affecting VAMCs. VA/VHA leaders should use performance management tools and activities to ensure the strategic goals are being met in an effective and efficient manner. It is a constant challenge to continuously and reliably measure the pulse of the organization. Site visits promote a healthy culture of sharing and building an understanding of organizational mission.

APPENDIX G: VETERAN FEEDBACK

In addition to the more than 4,000-page *Independent Assessment Report*, the Commission examined dozens of other reports, studies, and presentations as cited in the hundreds of footnotes dispersed throughout this Final Report. Collectively, these many sources provide a wealth of information on the challenges VHA confronts in realizing a vision for veterans' healthcare that leverages the strengths of VA and capitalizes on the potential non-VA providers offer.

A key source the Commission considered was the views of veterans themselves. Given the Commission's brief tenure, it was not possible to conduct a survey representative of the views of millions of veterans receiving health care from VHA. Instead, the Commission encouraged veterans to offer feedback on their health care experiences and the work of the Commission through its website. Many veterans service organizations (VSOs) also provided views representing their members in open sessions with the Commission and in formal letters and position statements directly to the Commission.

The feedback offered by veterans through the Commission's web site covered a range of health care topics, such as whether and to what extent care should be privatized, how much choice veterans should have in deciding on their care, and their assessment of the quality of care received. Not surprisingly, veterans (including a few who were also VA employees) are quite passionate about their views on health care. For the most part, veterans' feedback from the web site expressed opposition to efforts to *privatize* VHA, although a few did want more access to non-VA providers. The *Choice Program* was frequently criticized for long delays in appointments, convoluted or misapplied eligibility criteria, and issues with how providers should be reimbursed for treatment and how much the veteran should pay. When the quality of care was noted, on balance veterans praised the care received from VHA, with a few disappointed, especially when care was outsourced to non-VA providers. Because the feedback was unstructured, veterans could offer any observations they found pertinent.

The Disabled American Veterans (DAV) shared with the Commission a compendium of more than 4,000 verbatim comments on veterans' health care experiences gathered from their members during April 2016. The DAV reviewed the comments and categorized 82 percent of the comments as "overall positive experiences."⁸⁰⁴ The Commission staff reviewed the comments from DAV, with findings consistent to DAV's.

⁸⁰⁴ Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

VA Efforts to Gather Input on Veterans Views on Health Care

Like most institutions that provide products and services to customers, VA/VHA solicits input from veterans on their health care needs and their views on specific services VA/VHA provides. Surveys, focus groups, and in-depth interviews are the more typical means for gathering input from veterans. On occasion, VA, like most agencies, encourages veterans and others to submit comments on a particular aspect of VA services and benefits.⁸⁰⁵

The following sections describe the more typical methods employed by VA/VHA to gather input from veterans.

VHA Survey of Veterans' Health and Use of VHA

Conducted by the assistant deputy undersecretary for policy and planning, the survey of veteran enrollees' health and use of health care (Survey of Enrollees) is an annual survey of more than 40,000 veterans who are enrolled in VA's health care system. The Survey of Enrollees was initially designed to give VHA the information it needed to predict the demand for services in the future. The data are used to develop health care budgets and to assist VA with its annual enrollment decisions. Over the years, the data have also been used to analyze policy decisions, provide insights into specific populations and their perspectives, and inform management decisions affecting delivery of care. In addition to collecting basic demographic information, the survey explores insurance coverage, use of health care inside and outside of VA, pharmaceutical use, attitudes and perceptions about VHA services, perceived health status, and trends in smoking among veterans enrolled in the VHA system.⁸⁰⁶

Survey of Healthcare Experiences of Patients⁸⁰⁷

The Survey of Healthcare Experiences of Patients (SHEP) program was initiated in 2002 in an effort to create standardized survey instruments administered monthly to assess ambulatory and inpatient care. In an effort to standardize its survey instruments with other health care providers, SHEP now employs the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey methodology for VHA's primary care and inpatient medical and surgical services. These surveys are supported in the public domain by the CAHPS Consortium, Agency for Healthcare Research and Quality, Centers for Medicare and Medicaid Services, and National Committee for Quality Assurance. Although SHEP deployed the standardized CAHPS surveys,

⁸⁰⁵ "Quality of Care Feedback Form," Department of Veterans Affairs, accessed June 20, 2016, <http://www.va.gov/QUALITYOFCARE/apps/contact.asp>. As an example, the VA web site provides a Quality of Care feedback page for veterans and others to enter comments on the care a veteran received.

⁸⁰⁶ Westat, 2015 Survey of Veteran Enrollees' Health and Use of Health Care, accessed June 6, 2016, http://www.va.gov/healthpolicyplanning/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf.

⁸⁰⁷ For more details on SHEP and VHA's recent initiatives to expand the scope of the program, see "Health Services Research & Development, Commentary: Listening to Veterans about Access to Care," Steven M. Wright, VHA Office of Analytics and Business Intelligence, U.S. Department of Veterans Affairs, accessed June 20, 2016, <http://www.hsrd.research.va.gov/publications/forum/nov15/default.cfm?ForumMenu=nov15-1>.

the access questions were limited and did not evaluate the full scope of services used by veterans.

VHA intends to expand the SHEP program with additional surveys in 2016 and beyond. These surveys will focus on satisfaction with various specialty care services and experience with community care available through the Veterans Access, Choice, and Accountability Act of 2014. VHA has also launched a survey that focuses on new veteran enrollments and their experience with first clinic appointments.

Veteran Insights Panel

VHA also established a Veteran Insights Panel, comprising more than 3,200 veterans that are representative of users of VA health care.⁸⁰⁸ VHA interacts with the panel through email notification and a special access website (mobile device enabled). This approach provides VHA an opportunity to engage panel members in direct discussions, including real time feedback via live chat, about important themes and issues, and survey development and testing. The panel can be engaged collaboratively with operational program offices and researchers to prompt direct discussions with our veterans.

Voices of Veterans: On-going Research

Initiated in the spring of 2014, the VA Center for Innovation (VACI) sponsors an on-going effort to employ human-centered design (HCD)⁸⁰⁹ concepts in a pilot to explore veterans' experience with VA through the eyes of 40 veterans across a range of demographics and locations.⁸¹⁰ The pilot had two goals:

- To test the usefulness and application of an HCD methodology within the context of VA.
- To better understand veterans' experiences interacting with VA, identify pain points in the present day service delivery model, and explore opportunities to transform these interactions into a more veteran-centered experience.

Developing Veteran Personas

As a part of this pilot, VACI set out to identify high-level trends in ways veterans seek out assistance, use technology, take advantage of services, and react to challenging interactions. Based on these patterns, VACI created a set of four profiles, or personas, that represent the

⁸⁰⁸ Ibid.

⁸⁰⁹ Human-centered design (HCD) is a discipline in which the needs, behaviors and experiences of an organization's customers (or users) drive product, service, or technology design processes. It is a practice used heavily across the private sector to build a strong understanding of users, generate ideas for new products and services, test concepts with real people, and ultimately deliver easy-to-use products and positive customer experiences. HCD is a multi-disciplinary methodology which draws from the practices of ethnography, cognitive psychology, interaction and user experience design, service design, and design thinking. It is closely tied to "user-centered design," which applies parallel processes to technology projects, and "service design" which address the service specific experiences.

⁸¹⁰ U.S. Department of Veterans Affairs, Center for Innovation, *Toward a Veteran-Centered VA: Piloting Tools of Human-Centered Design for America's Vets, Findings Report, July 2014*, accessed June 20, 2016, http://www.innovation.va.gov/docs/Toward_A_Veteran_Centered_VA_JULY2014.pdf.

COMMISSION ON CARE FINAL REPORT

kinds of users within the set of 40 veterans engaged in the pilot (see Table G-1). Each persona is an archetype based on commonalities observed among veterans who exhibited similar behaviors and approaches to accessing VA services. They are not categorized by positive or negative experiences, but by shared expectations and needs. These personas were designed to help VHA begin to understand that it is serving users who are seeking not just different services, but also varied degrees of contact, support, information, and so forth. For this exercise, VACI assessed veterans' modes of communication, channels, frequency, stated and observed needs, reactions to service experiences, military service, and analyzed observed behavior and service experiences.

*Table G-1. Veteran Profiles Developed by the VA Center for Innovation*⁸¹¹

THE LIFER	THE TRANSACTIONAL
<p>Frequently use VA services and plans to continue doing so. Look to VA to play a supporting, community-building role in life. Grateful for VA benefits, but get frustrated when problems arise which break up the continuity of care—like when doctors change too frequently and when they cannot get transportation to VA facilities. Generally, try to speak highly of VA and wants to contribute to making it work better for fellow veterans.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA cares and takes the time to understand veteran's needs and story ▪ That cost of VA services won't rise ▪ That veteran can reach someone at VA anytime <p>Needs</p> <ul style="list-style-type: none"> ▪ Does not want to tell story over and over, especially after using VA for so long ▪ Wants to know what is going on with services and especially benefits ▪ Likes patient, nurturing health care 	<p>Joined the military largely based on the promise of the opportunities it would provide in life. Plan to use VA services to "get life on track" post-service. Tend to be in the younger generation of veterans (OEF, OIF, OND). Often engaged in the veteran community, see other veterans as allies, and advocates in helping folks understand and use their benefits. Will share frustrations if feels like VA is not helping as promised.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA will deliver on its promises and help veteran access the benefits earned ▪ That VA has benefits available to veterans families ▪ That it will be a headache, and veterans will have to figure it out on their own with the help of network <p>Needs</p> <ul style="list-style-type: none"> ▪ Accurate expectations ▪ Financial support at times, especially for family ▪ To feel a part of a community

⁸¹¹ Ibid.

THE JUST-IN-CASE	THE INFREQUENT
<p>Proud of service, but does not need VA and plans on using it only as a backup. Mature and organized by nature, has all papers in order with VA and have a good idea of services for which they are eligible. Grateful for the benefits available, but see working with VA as a tradeoff for time and will likely only lean on VA as a backup plan.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That will likely never need VA benefits ▪ That VA will be there if needed ▪ That there are benefits available to family ▪ That private benefits are of higher quality and greater ease <p>Needs</p> <ul style="list-style-type: none"> ▪ Peace of mind ▪ To be assured that all documents are in order ▪ To easily get in touch with one person about one question 	<p>Does not think very much about VA. Have used VA benefits in lifetime, yet often years will go by between those interactions. This might be because these veterans live in places where it is difficult to access VA services, because veterans are financially comfortable, or because it seems like too much hassle. Tend to prefer quick interaction—a short phone call or a few clicks on a website.</p> <p>Expectations</p> <ul style="list-style-type: none"> ▪ That VA is slow—like any bureaucracy ▪ That VA is for “other, injured veterans who need it more” ▪ That someone will tell veterans when and if they are eligible for something <p>Needs</p> <ul style="list-style-type: none"> ▪ To be able to quickly navigate processes ▪ To be reminded every few years of how VA might be able to help

Vantage Point: VA’s Official Blog

In addition to surveys, focus groups, and town-hall sessions, VA instituted a blog on its website and invites veterans and others interested in veterans matters to submit guest posts of potential interest to others in the community. Like most blogs, the content offered is vetted by the VA. Since 2010, Vantage Point includes hundreds of contributors with articles on various health care topics.⁸¹²

Veterans’ Views Gathered by VSOs

Like VHA, the VSOs solicit input from their membership and other stakeholders on a variety of topics and issues relevant to veterans. Occasionally surveys and polls are undertaken, but most VSO efforts to gather input take place at the grassroots level during town halls, chapter meetings and other gatherings. While these venues often suffer from self-selection bias and non- or under-represented participant samples, these are nevertheless an important source of timely information on topics of interest and concern to veterans. What follows is a selection of VSO efforts to gather input on issues important to veterans.

⁸¹² “Vantage Point: Official Blog of the U.S. Department of Veterans Affairs,” Department of Veterans Affairs, accessed June 20, 2016, <http://www.blogs.va.gov/VAntage/>.

The DAV Veterans Pulse Survey (2015)

In mid-2015 the DAV surveyed a nationally representative sample of veterans to solicit their views on issues important to veterans.⁸¹³ The survey includes questions on various aspects of veterans' healthcare. The survey consists of a national probability sample of 1,701 veterans intended to represent the veteran population in the United States. Oversampling occurred in certain subgroups, such as female veterans and veterans age 18-40 to allow for more precision in the response estimates for these subgroups.

Veterans of Foreign Wars Our Care Veterans Survey (2015)

In the fall of 2015, the Veterans of Foreign Wars of the U.S. (VFW) published a report on its veterans 2015 Health Care Options, Preferences and Expectations Survey.⁸¹⁴ In response to the intensified debate over reform of veterans' healthcare, the VFW launched a survey in the summer of 2015 designed to evaluate veterans' options, expectations, and preferences when seeking health care. The survey did not just focus on VA services, but sought to paint a picture of how the veterans' community at large interacts within the American health care infrastructure, and the choices they make in today's health care marketplace. According to the VFW report, 1,847 veterans responded to the survey, with 92 percent eligible for care and 83 percent of those eligible reporting that they utilize VA health care.⁸¹⁵ Respondents' average age was 65, with about two-thirds Vietnam War veterans.

VFW Survey of Women Veterans (2016)

In an effort to identify barriers women veterans face when accessing their earned veterans' benefits and services, the VFW has commissioned a survey of women veterans that will guide the VFW's policy priority goals for women veterans.⁸¹⁶ Though the survey data collection phase is completed, results have not been published prior to release of the Commission's Final Report.

⁸¹³ Disabled American Veterans (DAV), *The DAV Veterans Pulse Survey: A landmark study of the attitudes and perceptions of America's veterans*, accessed June 20, 2016, <https://www.dav.org/wp-content/uploads/DAV-Pulse-Report-Final.pdf>. The survey was conducted on behalf of DAV by GfK Knowledge Networks, Inc. using their KnowledgePanel® survey participants in November 2015.

⁸¹⁴ Veterans of Foreign Wars, *Our Care: A Report on Veterans' Options, Preferences and Expectations in Health Care*, September 22, 2015, accessed June 20, 2016, http://www.vfw.org/uploadedFiles/VFW.org/VFW_in_DC/VFWOurCareReport2015.pdf.

⁸¹⁵ *Ibid.*, 4.

⁸¹⁶ "VFW Survey of Women Veterans: Help Hold the VA Accountable," Veterans of Foreign Wars, December 22, 2015, accessed June 20, 2016, <http://www.vfw.org/News-and-Events/Articles/2015-Articles/VFW-Survey-of-Women-Veterans/>.

The American Legion Survey of Patient Health Care Experiences (2014)

This survey of 3,116 opt-in, self-reported veterans focuses on satisfaction and levels of perceived benefits with VA's posttraumatic stress disorder/traumatic brain injury (PTSD/TBI) programs, including alternative and complementary treatments.⁸¹⁷

Survey questions include veteran status; gender; era of service; number of times deployed; diagnosis of TBI and/or PTSD; availability of appointments; time and distance to care facilities; treatment type (therapy, medication and complementary and alternative medicine); reported symptoms; efficacy of treatment; and side effects.

The American Legion Women Veterans Survey Report (2011)

This survey of 3,012 women veterans, and the resulting report, was prepared by ProSidian Consulting, LLC on behalf of The American Legion. The survey assessed the perceptions of and satisfaction with women veterans' health care and other benefits delivered to women veterans through the VA system. Additionally, the survey sought to determine the factors driving women veterans' decision to use the VA system as opposed to other private or public health care systems.⁸¹⁸

Iraq and Afghanistan Veterans of America Member Survey (2015)

During the first half of 2015, 1,501 Iraq and Afghanistan Veterans of America members completed a wide-ranging on-line survey covering such issues as employment, education, GI Bill usage, health (including mental health), VA utilization, VA benefits, reintegration and more. The survey was composed of approximately 300 questions, with respondents answering only questions relevant to their experiences. Health care topics included percent enrollment in and reliance on VA care; health insurance coverage by type; and experience rating for VA care. Usage percent and experiencing rating for the VA *Choice Program* was also covered separately.⁸¹⁹

The 2015 Wounded Warrior Project® Alumni Survey

This web-enabled, opt-in survey of 23,200 Wounded Warrior Project (WWP) members measures a series of outcome domains within the following general topics about WWP Alumni: background information (military experiences and demographic data), physical and mental well-being, and economic empowerment.⁸²⁰ This WWP membership survey has been conducted annually since 2010. As it has done in prior years, Westat conducts the survey and population-

⁸¹⁷ "Legion survey to measure effectiveness of PTSD/TBI treatment," The American Legion, July 29, 2015, accessed June 20, 2016, <http://www.legion.org/pressrelease/229354/legion-survey-measure-effectiveness-ptsdtbi-treatment>.

⁸¹⁸ ProSidian Consulting, LLC, *The American Legion Women Veterans Survey Report*, March 9, 2011, accessed June 20, 2016, http://www.legion.org/documents/legion/pdf/womens_veterans_survey_report.pdf.

⁸¹⁹ "Media Advisory: IAVA to Release Groundbreaking Veterans Survey," Iraq and Afghanistan Veterans of America (IAVA), May 23, 2016, accessed June 20, 2016, <http://iava.org/press-release/media-advisory-iava-to-release-groundbreaking-veterans-survey-2/>.

⁸²⁰ Westat, *2015 Wounded Warrior Project Survey, Report of Findings*, August 14, 2015, accessed June 20, 2016, https://www.woundedwarriorproject.org/media/2118/2015_wwp_alumni_survey_full_report.pdf.

COMMISSION ON CARE FINAL REPORT

weights the reported results, to include adjustments for potential non-response bias, to be representative of the WWP membership base (approximately 59,000).

Right to Care: Voices of Swords to Plowshares' Veteran Community (2015)

The Swords to Plowshares, Institute for Veteran Policy interviewed in-person or by phone 22 veterans.⁸²¹ Although the topics were established in advance, Swords to Plowshares characterized these interviews as individual “conversations” with a preselected group of veterans. The veterans were chosen to represent a cross-section of combat eras and VHA usage levels. The topics covered included: navigating VA care, reliance on VA and non-VA care, comprehensiveness of care, and rating quality of care. The study includes extensive verbatim comments from veterans on these topics.

Comments from Veterans About Their Experiences as Users of VHA (DAV, 2016)

During April 2016, DAV reached out to veterans around the United States and asked them to share their experiences with the VA health care system. As a result, DAV received (as of April 2016) more than 4,000 responses from veterans sharing their own stories about the care they received from VHA.⁸²² The Commission’s review of the material showed that a majority of the veterans’ comments were positive in nature. DAV’s own analysis concluded that 82 percent of the comments could be categorized as “overall positive experiences.”

Other Surveys on Veterans Issues

In addition to efforts by VA and VSOs to gather feedback from veterans on their health care, other organizations have also addressed veterans’ health care issues.

Concerned Veterans for America Survey of Veterans' Healthcare (November, 2014)

The Concerned Veterans for America commissioned The Tarrance Group to conduct a national survey of 1,000 veterans during November 2014.⁸²³ This survey used a random, demographically representative sample of veterans. Four survey items addressed health care, including: knowledge of any problems at VA; need for reform of veterans’ healthcare; importance of more choice (or options) in health care for veterans; and importance of best possible veterans care, even if outside VA.

⁸²¹ Megan Zottarelli, *RIGHT to CARE: Voices of Swords to Plowshares' Veteran Community*, Swords to Plowshares, Institute for Veterans Policy, April 2016.

⁸²² Comments from veterans about their experiences as users of the VA health care system, printout provided to Commission on Care by Disabled American Veterans, April 2016.

⁸²³ Concerned Veterans for America, *Fixing Veterans Health Care*, A Bipartisan Policy Taskforce, accessed June 20, 2016, <http://cv4a.org/wp-content/uploads/2016/01/Fixing-Veterans-Healthcare.pdf>.

Vet Voice Foundation Survey of Veterans (October, 2015)

Chesapeake Beach Consulting and Lake Research Partners conducted 800 phone (landline and cell) interviews of veterans during October 2015. The results were population weighted by demographics. Topics included rating the job VA hospitals are doing in their area and the extent they favor/oppose privatizing some of VA's health care.

COMMISSION ON CARE FINAL REPORT

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX H: ADDITIONAL RESOURCES

The VHA health care system is immense and complex. This report provides background for the areas for which the Commission has made recommendations, yet this information is but a glimpse at the intricacies of veterans' health care. The resources below may serve as a starting point for those who would like to develop a deeper understanding of the topic than the Commission could address in this report.

Independent Assessment Report

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Volume 1: Integrated Report*, http://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment A (Demographics)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_A_Demographics.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment B (Health Care Capabilities)*, http://www.va.gov/opa/choiceact/documents/assessments/assessment_b_health_care_capabilities.pdf.

RAND Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment C (Care Authorities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_C_Care_Authorities.pdf.

Institute of Medicine of the National Academies, *Transforming Health Care Scheduling and Access: Getting to Now*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_D_Access_Standards.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment E (Workflow – Scheduling)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_E_Workflow_Scheduling.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment F (Workflow – Clinical)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_F_Workflow_Clinical.pdf.

COMMISSION ON CARE FINAL REPORT

Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment G (Staffing/Productivity/Time Allocation)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_G_Staffing_Productivity.pdf.

The MITRE Corporation, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment H (Health Information Technology)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_H_Health_Information_Technology.pdf.

Grant Thornton, *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment I (Business Processes)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_I_Business_Processes.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment J (Supplies)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_J_Supplies.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment K (Facilities)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_K_Facilities.pdf.

McKinsey & Company, Inc., *Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs, Assessment L (Leadership)*, http://www.va.gov/opa/choiceact/documents/assessments/Assessment_L_Leadership.pdf.

Veteran Health Competency Resources

American Nurses Foundation

The American Nurses Foundation, the philanthropic arm of the American Nurses Association, is launching an innovative web-based PTSD Toolkit for registered nurses. The toolkit provides easy to access information and simulation based on gaming techniques on how to identify, assess and refer veterans suffering from PTSD. www.nurseptsdtoolkit.org

American Osteopathic Association

The American Osteopathic Association (AOA) represents osteopathic physicians, many of whom are in primary care practice, and essentially all of whom treat America's veterans and their families. The AOA is raising awareness in the osteopathic community about the importance of having a comprehensive understanding of the unique physical and mental health care needs of our service members, veterans, and their families. The AOA is committed to ensuring that medical students, physicians, and other health care providers understand that an individual's physical and/or mental health condition may be linked to his or her military experience.

www.osteopathic.org/inside-aoa/public-policy/Pages/federal-initiatives.aspx

Center for Deployment Psychology

The Center for Deployment Psychology of the Uniformed Services University of the Health Sciences, Department of Medical and Clinical Psychology offer a wide variety of on-line courses and other resources to help uniformed clinical providers, VHA providers, and community clinicians provide care consistent with the needs and experience of military service members, veterans and their families.

<http://deploymentpsych.org/online-courses>

<http://deploymentpsych.org/military-culture-course-modules>

Rural Clergy Training Program

The Rural Clergy Training Program, an initiative of the VHA National Chaplain Center and the Office of Rural Health, offers training and information to clergy providing pastoral services to veterans and their families.

http://www.ruralhealth.va.gov/docs/ruralclergytraining/The_Clergy_Connection_December_2015.pdf

Swords to Plowshares Combat to Community Training

Swords to Plowshares is nationally recognized for its expertise in providing comprehensive services and promoting and protecting the rights of veterans. Swords to Plowshares' *Combat to Community*® training is a series of accredited cultural competency curricula developed by its Institute for Veteran Policy team with the purpose of educating the community to address the reintegration challenges veterans face and the unique skill sets they acquire in service. The training was developed for law enforcement, first responder, mental health, and service professionals to teach:

- Commonly shared attitudes, values, goals, and practice that often characterize service in the military
- Recruitment and retention strategies for veteran employment
- How deployment, combat experience, service related injuries, and disability can impact veterans
- How veteran or military family status can inform interactions and services
- Potential resources to refer veterans and families to for supportive services

The training incorporates knowledge developed by experts in the fields of veteran culture and direct services with practical tools and resources to increase understanding and improve interactions with veterans.

<https://www.swords-to-plowshares.org/combat-to-community>

COMMISSION ON CARE FINAL REPORT

VA Military Culture Training Courses on TMS

The resources below are available to VA employees and contractors. Versions of these courses should be made available to community providers through an alternative to TMS that allows outside providers to access the training.

- **Military Culture Training for Health Care Professionals – Organization and Roles (VA 19332)**

The first module of this online course provides an overview of the differences between the explicit and implicit features of military culture and describes the characteristics of implicit military culture. The next module identifies four sources of information about implicit military culture and describes six defining characteristics of warrior ethos. The learner is provided information about the influence of military guiding ideals and values on the lives of service members and veterans. The final module offers an overview regarding the connotations of implicit military culture on the health care professional.

- **Military Culture Training for Health Care Professionals: Self-Awareness and Military Ethos (VA 19333)**

This online course, sponsored by the Department of Veterans Affairs and Department of Defense, helps health care professionals understand the role that military culture plays in the lives of those they serve. The course is comprised of four modules: 1) Self-Assessment and Introduction to Military Ethos, 2) Military Organization and Roles, 3) Stressors and Their Impact, and 4) Treatment Resources and Tools.

- **Military Culture Training for Health Care Professionals: Stressors & Resources (VA 19334)**

This online course offers the learner an explanation of how stress can be either helpful or harmful depending on the nature of the provoking stressor and the availability of resources. The four phases of modern operational deployment cycles is presented in great detail in module 3. The next two modules describe the characteristic operational stressors and the spectrum of operational stress states and outcomes experienced by service members and their families during each deployment cycle phase.

- **Military Culture Training for Health Care Professionals: Treatment Resources, Prevention & Treatment (VA 19335)**

This online course in the military culture curriculum outlines the military culture impact on patient care and the health care professional's role and explains the range of DoD and VA psychological health services. The course also provides information on interpreting military culture knowledge into patient assessment and treatment. Finally, the learner is exposed to the military culture implications of VA/DoD clinical practice guidelines relevant to the care of service members and veterans and the strategies for identifying current military culture relevant patient and health care professional resources.

- **Military Cultural Awareness (NFED 1341520)**

This military cultural awareness online course provides a common foundation for all VA employees. This course offers an overview of common military culture and courtesies, roles and ranks within the military, differences between the branches of the armed services, some of the conflicts in which veterans have served, and why this information

is important in helping VA employees better serve the needs of veterans and their families. After taking this course, participants will understand the perspective of the veterans they serve by having a greater awareness of the military experience, and the customs and courtesies that are common in the military environment.

- **PTSD 101: Understanding Military Culture When Treating PTSD (VA 9494)**
This online web-based course is part of the PTSD 101 education series which is presented by subject-matter experts to increase provider knowledge related to the assessment and treatment issues of PTSD. Each course specifically addresses trauma events, treatments, or special population issues, not normally addressed in general therapy protocols. This course is specifically designed to familiarize clinicians with military culture, terminology, demographics, and stressors. It also provides an overview of programs offered by DoD for managing combat or operational stress, as well as implications for assessment and treatment.
- **Why Military Culture Matters (Mobile Accessible) (VA 16353)**
This independent online study activity is designed to help the learner better connect with veterans and understand how veterans' military experiences influence their health. This course is formatted to be accessible using a VA networked mobile device.

Additional Sources

- Asch, Steven M., Elizabeth A. McGlynn, Mary M. Hogan, Rodney A. Hayward, Paul Shekelle, Lisa Rubenstein, Joan Keese, John Adams, and Eve A. Kerr. "Comparison of Quality of Care for Patients in the Veterans Health Administration and Patients in a National Sample." *Annals of Internal Medicine*, 141, no. 12 (2004): 938-945. <http://doi.org/10.7326/0003-4819-141-12-200412210-00010>.
- Berlowitz, Dan R., Amy K. Rosen, Fei Wang, Dionyssios Tsilimingras, Pierre N. Tariot, Joe Engelhardt, Boris Kader, and Dana B. Mukamel. "Purchasing or Providing Nursing Home Care: Can Quality of Care Data Provide Guidance." *Journal of the American Geriatrics Society*, 53, no. 4 (2005): 603-608. <http://doi.org/10.1111/j.1532-5415.2005.53207.x>.
- Bohnert, Kipling M., Paul N. Pfeiffer, Benjamin R. Szymanski, and John F. McCarthy. "Continuation of Care Following an Initial Primary Care Visit with a Mental Health Diagnosis: Differences by Receipt of VHA Primary Care-Mental Health Integration Services." *General Hospital Psychiatry*, 35, no. 1 (2013): 66-70. <http://doi.org/10.1016/j.genhosppsych.2012.09.002>.
- Borzecki, Ann M., Cindy L. Christiansen, Susan Loveland, Priscilla Chew, and Amy K. Rosen. "Trends in the Inpatient Quality Indicators: the Veterans Health Administration Experience." *Medical Care*, 48, no. 8 (2010): 694-702. <http://doi.org/10.1097/MLR.0b013e3181e419e3>.
- Chi, Ru-Chien, Gayle E. Reiber, and Kathleen M. Neuzil. "Influenza and Pneumococcal Vaccination in Older Veterans: Results from the Behavioral Risk Factor Surveillance

COMMISSION ON CARE FINAL REPORT

- System." *Journal of the American Geriatrics Society*, 54, no. 2 (2006): 217–223.
<http://doi.org/10.1111/j.1532-5415.2005.00577.x>.
- De Luca, Susan M., John R. Blosnich, Elizabeth A. W. Hentschel, Erika King, and Sally Amen. "Mental Health Care Utilization: How Race, Ethnicity and Veteran Status are Associated with Seeking Help." *Community Mental Health Journal*, 52, no. 2 (2016): 174–179.
<http://doi.org/10.1007/s10597-015-9964-3>.
- Hoffmire, Claire A., Janet E. Kemp, and Robert M. Bossarte. "Changes in Suicide Mortality for Veterans and Nonveterans by Gender and History of VHA Service Use, 2000-2010." *Psychiatric Services*, 66, no. 9 (2015): 959–965. <http://doi.org/10.1176/appi.ps.201400031>.
- Jha, Ashish K., Jonathan B. Perlin, Kenneth W. Kizer, and R. Adams Dudley. "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care." *New England Journal of Medicine*, 348 (2003): 2218–2227. <http://doi.org/10.1056/NEJMsa021899>.
- Jha, Ashish K., Steven M. Wright, and Jonathan B. Perlin. "Performance Measures, Vaccinations, and Pneumonia Rates Among High-Risk Patients in Veterans Administration Health Care." *American Journal of Public Health*, 97, no. 12, 2167–2172.
<http://doi.org/10.2105/AJPH.2006.099440>.
- Karlin, Bradley. E., Gregory K. Brown, Mickey Trockel, Darby Cunning, Antonette M. Zeiss, and C. Barr Taylor. "National Dissemination of Cognitive Behavioral Therapy for Depression in the Department of Veterans Affairs Health Care System: Therapist and Patient-Level Outcomes." *Journal of Consulting and Clinical Psychology*, 80, no. 5 (2012): 707–718. <http://doi.org/10.1037/a0029328>
- Karlin, Bradley E., Josef I. Ruzek, Kathleen M. Chard, Afsoon Eftekhari, Candice M. Monson, Elizabeth A. Hembree, Patricia A. Resick, and Edna B. Foa. "Dissemination of Evidence-Based Psychological Treatments for Posttraumatic Stress Disorder in the Veterans Health Administration." *Journal of Traumatic Stress*, 23, no. 6 (2010): 663–673.
<http://doi.org/10.1002/jts.20588>.
- Keating, Nancy L., Mary Beth Landrum, Elizabeth B. Lamont, Samuel R. Bozeman, Steven H. Krasnow, Lawrence N. Shulman, Jennifer R. Brown, Craig C. Earle, William K. Oh, Michael Rabin, and Barbara J. McNeil. "Quality of Care for Older Patients with Cancer in the Veterans Health Administration Versus the Private Sector: A Cohort Study." *Annals of Internal Medicine*, 154, no. 11 (2011): 727–736. <http://doi.org/10.7326/0003-4819-154-11-201106070-00004>.
- Kerr, Eve A., Robert B. Gerzoff, Sarah L. Krein, Joseph V. Selby, John D. Piette, J. David Curb, William H. Herman, David G. Marrero, K.M. Venkat Narayan, Monika M. Safford, Theodore Thompson, and Carol M. Mangione. "Diabetes Care Quality in the Veterans Affairs Health Care System and Commercial Managed Care: The TRIAD Study." *Annals of Internal Medicine*, 141, no. 4 (2004): 272–281. <http://doi.org/10.7326/0003-4819-141-4-200408170-00007>.

- Kilbourne, Amy M., Rosalinda V. Ignacio, Hyungjin Myra Kim, and Frederic C. Blow. "Datapoints: Are VA Patients with Serious Mental Illness Dying Younger?" *Psychiatric Services*, 60, no. 5 (2015): 589. <http://doi.org/10.1176/appi.ps.60.5.589>.
- Krein, Sarah L., Timothy P. Hofer, Christine P. Kowalski, Russell N. Olmsted, Carol A. Kauffman, Jane H. Forman, Jane Banaszak-Holl, and Sanjay Saint. "Use of Central Venous Catheter-Related Bloodstream Infection Prevention Practices by US Hospitals." *Mayo Clinic Proceedings*, 82, no. 6 (2011): 672–678. <http://doi.org/10.4065/82.6.672>.
- Parikh-Patel, Arti, Cyllene R. Morris, Robert Martinsen, and Kenneth W. Kizer, "Disparities in Stage at Diagnosis, Survival, and Quality of Cancer Care in California by Source of Health Insurance." *California Cancer Reporting and Epidemiologic Surveillance Program, Institute for Population Health Improvement, University of California Davis*, October, 2015. <http://escholarship.org/uc/item/8xc078vj>.
- Petersen, Laura A., Sharon-Lise T. Normand, Jennifer Daley, and Barbara J. McNeil. "Outcome of Myocardial Infarction in Veterans Health Administration Patients as Compared with Medicare Patients." *New England Journal of Medicine*, 343, no. 26 (2000): 1934–1941. <http://doi.org/10.1056/NEJM200012283432606>.
- Petersen, Laura A., Sharon-Lise T. Normand, Lucian L. Leape, Barbara J. McNeil. "Comparison of Use of Medications After Acute Myocardial Infarction in the Veterans Health Administration and Medicare." *Circulation*, 104, no. 24 (2001): 2898–2904. <http://doi.org/10.1161/hc4901.100524>.
- Rehman, Shakaib U., Florence N. Hutchison, Katharine Hendrix, Eni C. Okonofua, Brent M. Egan. "Ethnic Differences in Blood Pressure Control Among Men at Veterans Affairs Clinics and Other Health Care Sites." *Archives of Internal Medicine*, 165, no. 9 (2005): 1041–1047. <http://doi.org/10.1001/archinte.165.9.1041>.
- Reiber, Gayle E., Thomas D. Koepsell, Charles Maynard, Linda B. Haas, and Edward J. Boyko. "Diabetes in Nonveterans, Veterans, and Veterans Receiving Department of Veterans Affairs Health Care." *Diabetes Care*, 27, Suppl. 2 (2004): B3–B9. http://dx.doi.org/10.2337/diacare.27.suppl_2.B3.
- Ross, Joseph S., Salomeh Keyhani, Patricia S. Keenan, Susannah M. Bernheim, Joan D. Penrod, Kenneth S. Boockvar, Alex D. Federman, Harlan M. Krumholz, and Albert L. Siu. "Use of Recommended Ambulatory Care Services: Is the Veterans Affairs Quality Gap Narrowing?" *Archives of Internal Medicine*, 168, no. 9 (2008): 950–958. <http://doi.org/10.1001/archinte.168.9.950>.
- Selim, Alfredo J., Dan Berlowitz, Lewis E. Kazis, William Rogers, Steven M. Wright, Shirley X. Qian, James A. Rothendler, Avron Spiro III, Donald Miller, Bernardo J. Selim, and Benjamin G. Fincke. "Comparison of Health Outcomes for Male Seniors in the Veterans Health Administration and Medicare Advantage Plans." *Health Services Research*, 45, no. 2 (2009): 376–396. <http://doi.org/10.1111/j.1475-6773.2009.01068.x>.
- Selim, Alfredo J., Lewis E. Kazis, William Rogers, Shirley Qian, James A. Rothendler, Austin Lee, Xinya S. Ren, Samuel C. Haffer, Russ Mardon, Donald Miller, Avron Spiro III, Bernardo

COMMISSION ON CARE FINAL REPORT

- J. Selim, and Benjamin G. Fincke. "Risk-Adjusted Mortality as an Indicator of Outcomes: Comparison of the Medicare Advantage Program with the Veterans' Health Administration." *Medical Care*, 44, no. 4 (2006): 359–365. <http://doi.org/10.1097/01.mlr.0000204119.27597.f1>.
- Trivedi, Amal N., and Regina C. Grebla. "Quality and Equity of Care in the Veterans Affairs Health-Care System and in Medicare Advantage Health Plans." *Medical Care*, 49, no. 6 (2011): 560–568. <http://doi.org/10.1097/MLR.0b013e31820fb0f6>.
- Trivedi, Amal N., Sierra Matula, Isomi Miake-Lye, Peter A. Glassman, Paul Shekelle, and Steven Asch. "Systematic Review: Comparison of the Quality of Medical Care in Veterans Affairs and Non-Veterans Affairs Settings." *Medical Care*, 49, no. 1 (2011): 76–88. <http://doi.org/10.1097/MLR.0b013e3181f53575>.
- Trockel, Mickey, Bradley E. Karlin, C. Barr Taylor, Gregory K. Brown, and Rachel Manber. "Effects of Cognitive Behavioral Therapy for Insomnia on Suicidal Ideation in Veterans." *SLEEP*, 38, no. 2 (2015): 259–265. <http://doi.org/10.5665/sleep.4410>.
- Watkins, Katherine E., Brad Smith, Ayse Akincigil, Melony E. Sorbero, Susan Paddock, Abigail Woodroffe, Cecilia Huang, Stephen Crystal, and Harold Alan Pincus. "The Quality of Medication Treatment for Mental Disorders in the Department of Veterans Affairs and in Private-Sector Plans." *Psychiatric Services*, 67, no. 4 (2016): <http://doi.org/10.1176/appi.ps.201400537>.
- Weeks, W. B., A. N. West, A. K. Rosen, and J. P. Bagian. "Comparing Measures of Patient Safety for Inpatient Care Provided to Veterans Within and Outside the VA System in New York." *Quality & Safety in Health Care*, 17, no. 1 (2007): 58–64. <http://doi.org/10.1136/qshc.2006.020735>.
- Wright, Steven M., Laura A. Petersen, Rebecca P. Lamkin, and Jennifer Daley. "Increasing Use of Medicare Services by Veterans with Acute Myocardial Infarction." *Medical Care*, 37, no. 6 (1999): 529–537.

APPENDIX I: ENABLING DOCUMENTS

Veterans Access, Choice, and Accountability Act of 2014

TITLE II—HEALTH CARE ADMINISTRATIVE MATTERS

SEC. 201. INDEPENDENT ASSESSMENT OF THE HEALTH CARE DELIVERY SYSTEMS AND MANAGEMENT PROCESSES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) INDEPENDENT ASSESSMENT. —

(1) **ASSESSMENT.** — Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into one or more contracts with a private sector entity or entities described in subsection (b) to conduct an independent assessment of the hospital care, medical services, and other health care furnished in medical facilities of the Department. Such assessment shall address each of the following:

(A) Current and projected demographics and unique health care needs of the patient population served by the Department.

(B) Current and projected health care capabilities and resources of the Department, including hospital care, medical services, and other health care furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to veterans.

(C) The authorities and mechanisms under which the Secretary may furnish hospital care, medical services, and other health care at non-Department facilities, including whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.

(D) The appropriate system-wide access standard applicable to hospital care, medical services, and other health care furnished by and through the Department, including an identification of appropriate access standards for each individual specialty and post-care rehabilitation.

(E) The workflow process at each medical facility of the Department for scheduling appointments for veterans to receive hospital care, medical services, or other health care from the Department.

(F) The organization, workflow processes, and tools used by the Department to support clinical staffing, access to care, effective length-of-stay management and care transitions, positive patient experience, accurate documentation, and subsequent coding of inpatient services.

COMMISSION ON CARE FINAL REPORT

(G) The staffing level at each medical facility of the Department and the productivity of each health care provider at such medical facility, compared with health care industry performance metrics, which may include an assessment of any of the following:

(i) The case load of, and number of patients treated by, each health care provider at such medical facility during an average week.

(ii) The time spent by such health care provider on matters other than the case load of such health care provider, including time spent by such health care provider as follows:

(1) At a medical facility that is affiliated with the Department.

(II) Conducting research.

(III) Training or supervising other health care professionals of the Department.

(H) The information technology strategies of the Department with respect to furnishing and managing health care, including an identification of any weaknesses and opportunities with respect to the technology used by Department, especially those strategies with respect to clinical documentation of episodes of hospital care, medical services, and other health care, including any clinical images and associated textual reports, furnished by the Department in Department or non-Department facilities.

(I) Business processes of the Veterans Health Administration, including processes relating to furnishing non-Department health care, insurance identification, third-party revenue collection, and vendor reimbursement, including an identification of mechanisms as follows:

(i) To avoid the payment of penalties to vendors.

(ii) To increase the collection of amounts owed to the Department for hospital care, medical services, or other health care provided by the Department for which reimbursement from a third party is authorized and to ensure that such amounts collected are accurate.

(iii) To increase the collection of any other amounts owed to the Department with respect to hospital care, medical services, and other health care and to ensure that such amounts collected are accurate.

(iv) To increase the accuracy and timeliness of Department payments to vendors and providers.

(J) The purchasing, distribution, and use of pharmaceuticals, medical and surgical supplies, medical devices, and health care related services by the Department, including the following:

(i) The prices paid for, standardization of, and use by the Department of the following:

(I) Pharmaceuticals.

(II) Medical and surgical supplies.

(III) Medical devices.

(ii) The use by the Department of group purchasing arrangements to purchase pharmaceuticals, medical and surgical supplies, medical devices, and health care related services.

(iii) The strategy and systems used by the Department to distribute pharmaceuticals, medical and surgical supplies, medical devices, and health care related services to Veterans Integrated Service Networks and medical facilities of the Department.

(K) The process of the Department for carrying out construction and maintenance projects at medical facilities of the Department and the medical facility leasing program of the Department.

(L) The competency of leadership with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management.

(2) PARTICULAR ELEMENTS OF CERTAIN ASSESSMENTS. —

(A) SCHEDULING ASSESSMENT. — In carrying out the assessment required by paragraph (1)I, the private sector entity or entities shall do the following:

(i) Review all training materials pertaining to scheduling of appointments at each medical facility of the Department.

(ii) Assess whether all employees of the Department conducting tasks related to scheduling are properly trained for conducting such tasks.

(iii) Assess whether changes in the technology or system used in scheduling appointments are necessary to limit access to the system to only those employees that have been properly trained in conducting such tasks.

(iv) Assess whether health care providers of the Department are making changes to their schedules that hinder the ability of employees conducting such tasks to perform such tasks.

(v) Assess whether the establishment of a centralized call center throughout the Department for scheduling appointments at medical facilities of the Department would improve the process of scheduling such appointments.

(vi) Assess whether booking templates for each medical facility or clinic of the Department would improve the process of scheduling such appointments.

(vii) Assess any interim technology changes or attempts by Department to internally develop a long-term scheduling solutions with respect to the feasibility and cost effectiveness of such internally developed solutions compared to commercially available solutions.

(viii) Recommend actions, if any, to be taken by the Department to improve the process for scheduling such appointments, including the following:

COMMISSION ON CARE FINAL REPORT

(1) Changes in training materials provided to employees of the Department with respect to conducting tasks related to scheduling such appointments.

(II) Changes in monitoring and assessment conducted by the Department of wait times of veterans for such appointments.

(III) Changes in the system used to schedule such appointments, including changes to improve how the Department—

(aa) measures wait times of veterans for such appointments;

(bb) monitors the availability of health care providers of the Department; and

(cc) provides veterans the ability to schedule such appointments.

(IV) Such other actions as the private sector entity or entities considers appropriate.

(B) MEDICAL CONSTRUCTION AND MAINTENANCE PROJECT AND LEASING PROGRAM ASSESSMENT.— In carrying out the assessment required by paragraph (1)(K), the private sector entity or entities shall do the following:

(i) Review the process of the Department for identifying and designing proposals for construction and maintenance projects at medical facilities of the Department and leases for medical facilities of the Department.

(ii) Assess the process through which the Department determines the following:

(1) That a construction or maintenance project or lease is necessary with respect to a medical facility or proposed medical facility of the Department.

(II) The proper size of such medical facility or proposed medical facility with respect to treating veterans in the catchment area of such medical facility or proposed medical facility.

(iii) Assess the management processes of the Department with respect to the capital management programs of the department, including processes relating to the methodology for construction and design of medical facilities of the Department, the management of projects relating to the construction and design of such facilities, and the activation of such facilities.

(iv) Assess the medical facility leasing program of the Department.

(3) TIMING.— The private sector entity or entities carrying out the assessment required by paragraph (1) shall complete such assessment not later than 240 days after entering into the contract described in such paragraph.

(b) PRIVATE SECTOR ENTITIES DESCRIBED.— A private entity described in this subsection is a private entity that—

(1) has experience and proven outcomes in optimizing the performance of the health care delivery systems of the Veterans Health Administration and the private sector and in health care management; and

(2) specializes in implementing large-scale organizational and cultural transformations, especially with respect to health care delivery systems.

(c) PROGRAM INTEGRATOR. —

(1) IN GENERAL. — If the Secretary enters into contracts with more than one private sector entity under subsection (a), the Secretary shall designate one such entity that is predominately a health care organization as the program integrator.

(2) RESPONSIBILITIES. — The program integrator designated pursuant to paragraph (1) shall be responsible for coordinating the outcomes of the assessments conducted by the private entities pursuant to such contracts.

(d) REPORT ON ASSESSMENT. —

(1) IN GENERAL. — Not later than 60 days after completing the assessment required by subsection (a), the private sector entity or entities carrying out such assessment shall submit to the Secretary of Veterans Affairs, the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Commission on Care established under section 202 a report on the findings and recommendations of the private sector entity or entities with respect to such assessment.

(2) PUBLICATION. — Not later than 30 days after receiving the report under paragraph (1), the Secretary shall publish such report in the Federal Register and on an Internet website of the Department of Veterans Affairs that is accessible to the public.

(e) NON-DEPARTMENT FACILITIES DEFINED. — In this section, the term “non-Department facilities” has the meaning given that term in section 1701 of title 38, United States Code.

SEC. 202. COMMISSION ON CARE.

(a) ESTABLISHMENT OF COMMISSION. —

(1) IN GENERAL. — There is established a commission, to be known as the “Commission on Care” (in this section referred to as the “Commission”), to examine the access of veterans to health care from the Department of Veterans Affairs and strategically examine how best to organize the Veterans Health Administration, locate health care resources, and deliver health care to veterans during the 20-year period beginning on the date of the enactment of this Act.

(2) MEMBERSHIP. —

(A) VOTING MEMBERS. — The Commission shall be composed of 15 voting members who are appointed as follows:

(i) Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

COMMISSION ON CARE FINAL REPORT

(ii) Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a veteran.

(iii) Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a veteran.

(iv) Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a veteran.

(v) Three members appointed by the President, at least two of whom shall be veterans.

(B) QUALIFICATIONS. — Of the members appointed under subparagraph (A) —

(i) at least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of veterans under section 5902 of title 38, United States Code;

(ii) at least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;

(iii) at least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)));

(iv) at least one member shall be familiar with the Veterans Health Administration but shall not be currently employed by the Veterans Health Administration; and

(v) at least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.

I DATE. — The appointments of members of the Commission shall be made not later than 1 year after the date of the enactment of this Act.

(3) PERIOD OF APPOINTMENT. —

(A) IN GENERAL. — Members shall be appointed for the life of the Commission.

(B) VACANCIES. — Any vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the original appointment.

(4) INITIAL MEETING. — Not later than 15 days after the date on which eight voting members of the Commission have been appointed, the Commission shall hold its first meeting.

(5) MEETINGS. — The Commission shall meet at the call of the Chairperson.

(6) QUORUM. — A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.

(7) CHAIRPERSON AND VICE CHAIRPERSON. — The President shall designate a member of the commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.

(b) DUTIES OF COMMISSION. —

(1) EVALUATION AND ASSESSMENT. — The Commission shall undertake a comprehensive evaluation and assessment of access to health care at the Department of Veterans Affairs.

(2) MATTERS EVALUATED AND ASSESSED. — In undertaking the comprehensive evaluation and assessment required by paragraph (1), the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201, including any findings, data, or recommendations included in such assessment.

(3) REPORTS. — The Commission shall submit to the President, through the Secretary of Veterans Affairs, reports as follows:

(A) Not later than 90 days after the date of the initial meeting of the Commission, an interim report on —

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(B) Not later than 180 days after the date of the initial meeting of the Commission, a final report on —

(i) the findings of the Commission with respect to the evaluation and assessment required by this subsection; and

(ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through the Veterans Health Administration.

(c) POWERS OF THE COMMISSION. —

(1) HEARINGS. — The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Commission considers advisable to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES. — The Commission may secure directly from any Federal agency such information as the Commission considers necessary to carry out this section. Upon request of the Chairperson of the Commission, the head of such agency shall furnish such information to the Commission.

(d) COMMISSION PERSONNEL MATTERS. —

(1) COMPENSATION OF MEMBERS. —

(A) IN GENERAL. — Each member of the Commission who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily

COMMISSION ON CARE FINAL REPORT

equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission.

(B) OFFICERS OR EMPLOYEES OF THE UNITED STATES. — All members of the Commission who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

(2) TRAVEL EXPENSES. — The members of the Commission shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Commission.

(3) STAFF. —

(A) IN GENERAL. — The Chairperson of the Commission may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the Commission to perform its duties. The employment of an executive director shall be subject to confirmation by the Commission.

(B) COMPENSATION. — The Chairperson of the Commission may fix the compensation of the executive director and other personnel without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

(4) DETAIL OF GOVERNMENT EMPLOYEES. — Any Federal Government employee may be detailed to the Commission without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(5) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES. — The Chairperson of the Commission may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(e) TERMINATION OF THE COMMISSION. — The Commission shall terminate 30 days after the date on which the Commission submits the report under subsection (b)(3)(B).

(f) FUNDING. — The Secretary of Veterans Affairs shall make available to the Commission from amounts appropriated or otherwise made available to the Secretary such amounts as the Secretary and the Chairperson of the Commission jointly consider appropriate for the Commission to perform its duties under this section.

(g) EXECUTIVE ACTION. —

(1) ACTION ON RECOMMENDATIONS. — The President shall require the Secretary of Veterans Affairs and such other heads of relevant Federal departments and agencies to

implement each recommendation set forth in a report submitted under subsection (b)(3) that the President —

(A) considers feasible and advisable; and

(B) determines can be implemented without further legislative action.

(2) REPORTS. — Not later than 60 days after the date on which the President receives a report under subsection (b)(3), the President shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives and such other committees of Congress as the President considers appropriate a report setting forth the following:

(A) an assessment of the feasibility and advisability of each recommendation contained in the report received by the President.

(B) For each recommendation assessed as feasible and advisable under subparagraph (A) the following:

(i) Whether such recommendation requires legislative action.

(ii) If such recommendation requires legislative action, a recommendation concerning such legislative action.

(iii) A description of any administrative action already taken to carry out such recommendation.

(iv) A description of any administrative action the President intends to be taken to carry out such recommendation and by whom.

H.R. 4437: Extension of Deadline for Submittal of Final Report by Commission on Care

[114th Congress Public Law 131]

[[Page 130 STAT. 292]]

Public Law 114-131

114th Congress

An Act

To extend the deadline for the submittal of the final report required by the Commission on Care.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. 38 USC 1701; EXTENSION OF DEADLINE FOR SUBMITTAL OF FINAL REPORT BY COMMISSION ON CARE.

COMMISSION ON CARE FINAL REPORT

Section 202(b)(3)(B) of the Veterans Access, Choice, and Accountability Act of 2014, 128 Stat. 1775 (Public Law 113-146; 128 Stat. 1773) is amended by striking “Not later than 180 days after the date of the initial meeting of the Commission” and inserting “Not later than June 30, 2016”.

Approved February 29, 2016.

DEPARTMENT OF VETERANS AFFAIRS
CHARTER OF THE
COMMISSION ON CARE

1. OFFICIAL DESIGNATION: Commission on Care
2. AUTHORITY: The Commission on Care established as required by section 202 of the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), Public Law 113-146, and operates under the provisions of the Federal Advisory Committee Act (FACA), as amended, 5 U.S.C. App. 2.
3. OBJECTIVES AND SCOPE OF ACTIVITIES: The Commission on Care (the "Commission") is established to examine the access of Veterans to health care from the Department of Veterans Affairs (VA) and strategically examine how best to organize the Veterans Health Administration (VHA), locate health care resources, and deliver health care to Veterans during the 20-year period beginning on the date of the enactment of VACAA, August 7, 2014.
4. DUTIES OF THE COMMISSION:
 - A. Evaluation and Assessment: In accordance with section 202(b)(1), the Commission shall undertake a comprehensive evaluation and assessment of access to health care at VA.
 - B. Matters Evaluated and Assessed: In undertaking the comprehensive evaluation and assessment required by section 202(b)(1) of VACAA and paragraph (4)(A) above, the Commission shall evaluate and assess the results of the assessment conducted by the private sector entity or entities under section 201 of VACAA, including any findings, data, or recommendations included in such assessment.
 - C. Reports: In accordance with section 202(b)(3) of VACAA, submit an interim report not later than 90 days after the initial meeting of the Commission to the President, through the Secretary of Veterans Affairs, and a final report not later than 180 days after the initial meeting of the Commission. The reports shall include (i) the findings of the Commission with respect to the evaluation and assessment required by section 202(b)(1); and (ii) such recommendations as the Commission may have for legislative or administrative action to improve access to health care through VHA.
5. OFFICIAL TO WHOM THE COMMISSION REPORTS: The Commission reports to the President, through the Secretary of Veterans Affairs.

VA is responsible for ensuring the reporting requirements of Section 6(b) of the FACA are fulfilled.


COMMISSION ON CARE FINAL REPORT

6. OFFICE RESPONSIBLE FOR PROVIDING THE NECESSARY SUPPORT FOR THE COMMISSION: VHA is responsible for providing support to the Commission.
7. ESTIMATED ANNUAL OPERATING COSTS AND STAFF-YEARS: Annual operating cost for the Commission is estimated at \$3,600,000 per year, including compensation of members and staff, in accordance with section 202(d) of VACAA. All members will receive travel expenses and a per diem allowance in accordance with the Federal Travel Regulations for any travel made in connection with their duties as members of the Commission. Approximately 15 FTE are anticipated.
8. DESIGNATED FEDERAL OFFICER: The Designated Federal Officer (DFO) or an Alternate DFO, full-time or permanent part-time VA employees, will be present at all meetings, including subcommittee meetings. The DFO will work with the Commission Chair to schedule the meetings and develop meeting agendas. The DFO is authorized to adjourn any meeting when he or she determines it is in the public interest to do so.
9. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Commission will meet at the call of the Chair for the duration of the Commission. The Commission may hold such hearings, sit and act at such times and places, and take such testimony, and receive such evidence as the Commission considers advisable to carry out its duties under section 202 of VACAA. A majority of the members of the Commission shall constitute a quorum, but a lesser number of members may hold hearings.
10. DURATION: The Commission is subject to the termination date as specified below in section 11.
11. TERMINATION: The Commission shall terminate 30 days after the date on which the Commission submits the final report required by section 202(b)(3)(B) of VACAA.
12. MEMBERSHIP: The Commission shall be composed of 15 voting members who are appointed as Special Government Employees and described in paragraph (A) below for the life of the Commission and have the qualifications described in paragraph (B) below:
 - A. APPOINTMENT AUTHORITY:
 - i. Three members appointed by the Speaker of the House of Representatives, at least one of whom shall be a Veteran.
 - ii. Three members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a Veteran.

- iii. Three members appointed by the Majority Leader of the Senate, at least one of whom shall be a Veteran.
 - iv. Three members appointed by the Minority Leader of the Senate, at least one of whom shall be a Veteran.
 - v. Three members appointed by the President, at least two of whom shall be Veterans.
- B. QUALIFICATIONS: Of the members appointed under 12(A) –
- i. At least one member shall represent an organization recognized by the Secretary of Veterans Affairs for the representation of Veterans under 38 U.S.C. 5902;
 - ii. At least one member shall have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50,000,000;
 - iii. At least one member shall be familiar with government health care systems, including those systems of the Department of Defense, the Indian Health Service, and Federally-qualified health centers (as defined by in section 1905(1)(2)(B) of the Social Security Act (42 U.S.C. 1396d(1)(2)(B));
 - iv. At least one member shall be familiar with VHA but shall not be currently employed by VHA; and
 - v. At least one member shall be familiar with medical facility construction and leasing projects carried out by government entities and have experience in the building trades, including construction, engineering, and architecture.
- C. CHAIRPERSON AND VICE CHAIRPERSON: The President shall designate a member of the Commission to serve as Chairperson of the Commission. The Commission shall select a Vice Chairperson from among its members.
- D. VACANCIES: If a vacancy occurs, it shall be filled in the same manner as the original appointment.
13. SUBCOMMITTEES: The Commission is authorized to establish subcommittees, with DFO approval, to perform specific projects or assignments as necessary and consistent with its mission. The Commission Chair shall notify the Secretary, through the DFO, of the establishment of any subcommittee, including its function, membership, and estimated duration. Subcommittees will report back to the Commission.
14. RECORDKEEPING: Records of the Committee shall be handled in accordance with General Records Schedule 26 or other approved agency records disposition schedules. Those records shall be available for public inspection and copying, subject to the Freedom of Information Act 5, U.S.C. 552.

COMMISSION ON CARE FINAL REPORT

15. DATE CHARTER IS FILED:

Approved:  Date 7/14/15
Robert A. McDonald
Secretary of Veterans Affairs



APPENDIX J:

COMPOSITION OF THE COMMISSION

Nancy M. Schlichting, Chairperson

Appointed by President Barack Obama

Nancy M. Schlichting is Chief Executive Officer of Henry Ford Health System (HFHS), a nationally recognized \$5 billion health care organization with 27,000 employees and recipient of the 2011 Malcolm Baldrige National Quality Award, 2011 John M. Eisenberg Patient Safety Quality Award, and 2004 Foster G. McGaw Award. She is credited with leading the health system through a dramatic financial turnaround and for award-winning patient safety, customer service and diversity initiatives.

Schlichting joined HFHS in 1998 as its Senior Vice President and Chief Administrative Officer, served as Executive Vice President and Chief Operating Officer, President and CEO of Henry Ford Hospital and was named President and CEO of the System in 2003. Her career in health care administration spans over 35 years of experience in senior level executive positions.

Schlichting serves on several national and community boards including The Kresge Foundation, Walgreens Boots Alliance, the Federal Reserve Bank of Chicago – Detroit Branch, the Detroit Regional Chamber, the Detroit Economic Club, and the Downtown Detroit Partnership. Nancy is also a Fellow of the American College of Healthcare Executives.

In 2015, Schlichting was honored as one of the 100 Most Influential People in Healthcare by Modern Healthcare magazine, the eighth time she received this recognition. She was also named to the Top 25 Women in Healthcare by Modern Healthcare, the fourth time she received this recognition and the only Michigander named to the list. Her other awards include: NCHL Gail L. Warden Leadership Excellence award, ACHE Senior-Level Healthcare Executive Regent's Award, AHA/HRET 2014 TRUST Award, Becker's Hospital Review "40 of the Smartest People in Healthcare-2014," Crain's Detroit Business "2012 Newsmaker of the Year," HealthLeaders Media "20 People Who Make Healthcare Better-2012," and most recently was named one of "Crain's 100 Most Influential Women in Michigan."

Author of the acclaimed book, *Unconventional Leadership*, Schlichting is a highly regarded expert and accomplished speaker on strategic leadership, quality, patient/family-centered care, and diversity.

Schlichting received her A.B. in Public Policy Studies, Magna Cum Laude from Duke University and her M.B.A. from Cornell University. She has also been the recipient of honorary doctoral degrees from Walsh College, Eastern Michigan University and Central Michigan University.

COMMISSION ON CARE FINAL REPORT

Delos M. (Toby) Cosgrove, MD, Vice Chairperson*Appointed by Speaker of the House John Boehner*

Toby Cosgrove, CEO of Cleveland Clinic, presides over a \$6.2 billion health care system comprising Cleveland Clinic, eight community hospitals, 16 family health and ambulatory surgery centers, Cleveland Clinic Florida, the Lou Ruvo Center for Brain Health in Las Vegas, Cleveland Clinic Toronto, and Cleveland Clinic Abu Dhabi. His leadership has emphasized patient care and patient experience, including the reorganization of clinical services into patient-centered, organ- and disease-based institutes. He launched major wellness initiatives for patients, employees, and communities. Under his leadership, Cleveland Clinic has consistently been named among America's top four hospitals by U.S. News & World Report and is one of only two hospitals named among America's 99 Most Ethical Companies by the Ethisphere Institute.

Cosgrove was a surgeon in the U.S. Air Force and served in Da Nang, Republic of Vietnam, as the chief of U.S. Air Force casualty staging flight. He received the Bronze Star and the Republic of Vietnam Commendation Medal.

He has published nearly 450 journal articles, book chapters, one book, and 17 training and continuing medical education films. He performed more than 22,000 operations and earned an international reputation for expertise in all areas of cardiac surgery, especially valve repair. As an innovator, Cosgrove has 30 patents filed for developing medical and clinical products used in surgical environments.

Cosgrove received his medical degree from the University of Virginia School of Medicine in Charlottesville, VA, and completed his clinical training at Massachusetts General Hospital, Boston Children's Hospital, and Brook General Hospital in London. He received a BA in biology from Williams College in Williamstown, MA.

Michael A. Blecker*Appointed by House Minority Leader Nancy Pelosi*

Michael Blecker has been associated with Swords to Plowshares since 1976 and has served as Executive Director since 1982. The agency was started in 1974 by returning Vietnam veterans and VISTA volunteers assigned to the VA regional office in San Francisco.

In the 1980s, when homelessness exploded, Swords to Plowshares started a transitional housing program with funding support from VA and the city and county of San Francisco. Swords to Plowshares continues to provide housing, employment, case management, and benefits advocacy for veterans from offices in San Francisco and Oakland. In 2005, the Iraq Vet Project (IVP) was established to help veterans of those wars and to shape policies affecting them. Recognizing Swords to Plowshares' long and effective history of challenging and shaping public policy with regard to veterans, in 2011, the IVP became known as the Institute for Veterans Policy.

Under Blecker's leadership, Swords to Plowshares' annual budget has grown from \$75,000 to nearly \$16 million. He has a nationwide reputation for dedicated service and as an authority on

veterans' services and veterans' rights. He served on the Advisory Committee on Homeless Veterans (2002-2007), which advises the Secretary of Veterans Affairs. He is cofounder of both the National Coalition for Homeless Veterans and the California Association of Veterans' Service Agencies. He has served on the Congressional Commission on Service Members and Veterans Transition Assistance, the California Senate Commission on Homeless Veterans, the San Francisco Mayor's Homeless Planning Committee, the National Agent Orange Settlement Advisory Board, The Agent Orange Information Center, and the Veterans Speakers Alliance.

Blecker served in the U.S. Army as a combat infantryman in Vietnam in 1968-69 with the 101st Airborne Division, achieving the rank of E-5. He received an AB degree in criminology from University of California, Berkeley and a JD degree from New College of California Law School.

David P. Blom

Appointed by Speaker of the House John Boehner

David Blom has been instrumental in the development and growth of the OhioHealth system. He has served as president of OhioHealth's central Ohio hospitals – Grant Medical Center, Riverside Methodist Hospital, and Doctors Hospital – while also serving as executive vice president and chief operating officer of OhioHealth. He was named president and CEO of OhioHealth in March 2002. He has a track record of achievement with a solid understanding of complex issues facing health care delivery. He has expertise in leading strategic initiatives, managing and developing human capital, improving profitability, and improving quality of care and customer experience.

Blom maintains many professional and community affiliations, currently serving as a board member of the Voluntary Hospitals of America (VHA), a member and treasurer of Columbus' Downtown Development Corporation (CDDC), member of the Columbus Partnership, and member of the local World President's Organization (WPO). In 2001, he was named a Top 100 Business Leader by Smart Business and in 2012 CEO of the Year by Columbus CEO Magazine.

He received a BA from Ohio State University and an MA in health care administration from The George Washington University.

David W. Gorman

Appointed by President Barack Obama

David Gorman is a retired, combat-disabled veteran of the Vietnam War, who was appointed executive director of the Disabled American Veterans (DAV) National Service and Legislative Headquarters in Washington, DC in 1995. His responsibilities include oversight of the DAV National Service, Legislative, and Voluntary Service Programs. He is the organization's principal spokesperson before Congress, the White House, and the U.S. Department of Veterans Affairs.

Gorman entered the U.S. Army in 1969 and served with the 173rd Airborne Brigade, the famed "Sky Soldiers" of the Vietnam War. During a campaign to secure an area in Central Vietnam

COMMISSION ON CARE FINAL REPORT

where U.S. forces suffered extremely high casualties, Mr. Gorman was severely wounded. His wounds required amputation of both legs.

Discharged from the Army in 1970, he immediately joined the DAV and is currently a life member of the DAV's National Amputation Chapter and DAV Chapter 39 in Greer, SC.

Gorman retired from his post executive director at the Washington Headquarters for Disabled American Veterans and now resides in Simpsonville, SC. Gorman attended Cape Cod Community College.

The Honorable Thomas E. Harvey, Esq.

Appointed by Senate Majority Leader Mitch McConnell

Thomas Harvey is a Vietnam combat veteran whose decorations include the Silver Star, the Purple Heart and 12 others for valor and service. In Vietnam, he spent a year as a company commander with the 173rd Airborne brigade and a year and a half as an advisor with the Vietnamese Airborne Division.

A lawyer by training, Harvey has spent much of his professional career working with veterans and issues of concern to them. He has served as Chief Counsel and Staff Director of the Senate Veterans Affairs Committee, Deputy Administrator of the Veterans Administration, and Assistant Secretary for Congressional Affairs of the Department of Veterans Affairs. Following 5 years with a major Wall Street law firm, Harvey came to Washington, DC, in 1977 as a White House fellow, serving as an assistant to ADM Stansfield Turner, then director of the Central Intelligence Agency. He has also served in the Department of Defense and as General Counsel and Congressional Liaison of the United States Information Agency. For 5 years, he was Senior Counselor of the Institute of International Education, which administers the Fulbright Program on behalf of the U.S. Department of State, as well as a number of other international educational exchange programs.

He currently serves on the boards of the Milbank Memorial Fund, the focus of which is public health policy, and of the Art Students League of New York, where he studies watercolor painting. He holds both BA and JD degrees from the University of Notre Dame and a LLM degree from the New York University School of Law.

Maj. Stewart M. Hickey, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Since 2011, Stewart Hickey has served as American Veterans (AMVETS) National Executive Director, operating the nation's fourth largest congressionally chartered veterans service organization and its subordinate organizations, and the daily advocacy of issues affecting veterans, national security, foreign affairs, and the economy.

Previously, Hickey was chief executive officer for the Hyndman (Pennsylvania) Area Health Center, a multisite community health center providing medical and dental services to several counties of Pennsylvania, West Virginia, and Maryland. His health care administration experience includes serving as chief human resources officer and chief operating officer of

Western Maryland Hospital Center in Hagerstown, Maryland, a 123-bed Joint Commission on Accreditation of Healthcare Organizations accredited, long-term care and sub-acute hospital with rehabilitation, occupational therapy, physical therapy, and respiratory care.

Hickey enlisted in the U.S. Marine Corps Reserve in February 1977, in Cumberland, MD, as an infantryman, and transferred to platoon leaders class in the summer of 1978. He served in Operation Desert Storm and Desert Shield and was awarded a Bronze Star Medal with Combat "V" for his achievements as commanding officer, Company D, Third Tank Battalion, Task Force RIPPER, 1st Marine Division, I Marine Expeditionary Force, Saudi Arabia from September 1990 to February 1991. His military education includes the Basic School, Armor Officer Basic, Amphibious Warfare School, Armor Officer Advanced Course, and Marine Corps Command and Staff College.

Hickey resides on his family farm in Cumberland Valley Township in McConnellsburg, PA. He and his wife, Ellen, have five children: Monroe, Ali, Charles, Andrew, and Bryce. Three of his sons, Andrew, Monroe, and Charles, followed their father's path and currently serve in the U.S. military.

Hickey received a BA in history from Penn State University and an MA in management from Webster University.

Rear Adm. Joyce M. Johnson, DO, US PHS (ret.)

Appointed by President Barack Obama

Joyce Johnson is a physician with senior public health leadership experience in civilian and military sectors.

Johnson served in the U.S. Public Health Service (Rear Admiral, Upper Half). Her last active-duty assignment was with the U.S. Coast Guard as Director, Health and Safety ("surgeon general"). She managed the Coast Guard's health care system, including 150 sickbays and clinics, and coordinated both medical and behavioral health care for the beneficiary population. She also had responsibility for the Coast Guard's safety and work-life programs. She held a Top Secret security clearance.

Other government assignments included senior scientific and management positions with the Food and Drug Administration (pharmaceutical safety and post-market surveillance) and the Substance Abuse and Mental Health Services Administration. She has held clinical positions at the National Institute of Mental Health and the Department of Veterans Affairs. At the Centers for Disease Control and Prevention, she was an Epidemiologic Intelligence Service (EIS) Officer and staff epidemiologist in the Center for Infectious Disease.

In the private sector, Johnson served as vice president, health sciences and chief medical officer for a large research organization, where she managed a portfolio of government contracts, including laboratory and social sciences research, and held a top secret security clearance.

Johnson is an osteopathic physician board certified in psychiatry and public health/preventive medicine. She is also a certified clinical pharmacologist and certified addiction specialist. In

COMMISSION ON CARE FINAL REPORT

addition to her medical degree, she earned a master's degree in hospital and health administration. She has been conferred six honorary doctoral degrees. She is a Distinguished Life Fellow of the American Psychiatric Association.

Johnson has extensive international health experience on all seven continents. She has particular interests in global mental health, health systems development, infectious disease, and disaster relief. She has led five Flag Expeditions with the Explorers Club. For more than a decade she has been a consultant to the National Science Foundation on the health care system in Antarctica.

Johnson recently coauthored the book, *Lizard Bites and Street Riots, Travel Emergencies and Your Health, Safety and Security*, and writes a monthly medical column. She is a Clinical Professor and Adjunct Professor at Georgetown University. She has served on expert committees including the Committee on Substance Abuse in the Military, National Academy of Medicine. She is active in numerous professional associations including the American Psychiatric Association, serving on the Committee on Psychiatric Dimensions of Disasters; the American Osteopathic Association, serving on the Bureau of International Osteopathic Medicine; and the Explorers Club, serving on the Medical Committee.

The Honorable Ikram U. Khan, MD

Appointed by Senate Minority Leader Harry Reid

Ikram Khan currently, he is president and 50-percent partner of Quality Care Consultants, LLC, founded in March 1992. The company provides consultant services in health care strategy and policy development for employers and other health care organizations. The company assists clients in development and implementation of wellness and disease-management programs. The company also develops quality improvement initiatives and techniques and assists in development and implementation of programs for cost-effective utilization of medical resources. Major emphasis is on clinical outcomes and data monitoring analysis.

Khan is a member the United States Institute of Peace (USIP) Board of Directors; he was nominated by President George Bush, and confirmed by the U.S. Senate on June 5, 2008. He is also currently a member of the Nevada Homeland Security Commission, having been appointed by the Governor of Nevada.

He was nominated by President Clinton and confirmed by the U.S. Senate to serve as member of The Board of Regents Uniformed Services University of Health Sciences, an advisory board to U.S. Secretary of Defense (1999-2006).

Khan also served as Special Advisor on Healthcare to Former Nevada Governor Gibbons, was a member of the Nevada Academy of Health (appointed by Nevada Governor Gibbons), and is a past member of the Nevada Academy of Health Sciences (appointed by Nevada Governor Kenny Guinn). He is past member of Nevada Governor's Commission for Medical Education, Research and Training and was a member of the Nevada State Board of Medical Examiners for eight years. Dr. Khan received "Special Congressional Recognition" for invaluable community service in 1994 and a Congressional citation—"U.S. Senate - Honoring Dr. Ikram Khan"—on April 25, 1994.

Khan currently serves as member on the board of trustees at Sunrise Hospital Las Vegas-a 600 bed hospital. He has received recognition as “Most Influential Man in Southern Nevada” in 2000. He is also a recipient of a Las Vegas Chamber of Commerce community achievement award (October 1999), and a “Distinguished Community Service Award” from Anti-defamation League of B’nai B’rith (1994).

November 30, 1999 was declared “Dr. Ikram U. Khan Day” by the Governor of the State of Nevada, Mayor of Las Vegas, and the Board of Commissioners of Clark County.

During the course of his practice as General Surgeon, Khan has served in multiple leadership positions at various hospitals in Las Vegas.

Ikram Khan is president of quality Care Consultants LLC in Las Vegas Nevada. He received a doctor of medicine and surgery (MBBS) degree from University of Karachi, Pakistan.

Khan received a Doctor of Medicine and Surgery (MB, BS) in August 1972 from the University of Karachi, Pakistan. He completed post-graduate surgical residency in General Surgery in New York from 1974 through 1978, and practiced as a General Surgeon in Las Vegas through 2005.

Phillip J. Longman

Appointed by Senate Minority Leader Harry Reid

Phil Longman is a director at New America, a public policy institute. He is also a senior editor at the Washington Monthly and a lecturer at Johns Hopkins University, where he teaches a course in health care policy.

Longman has written extensively on issues related to health care delivery system reform, including in his book *Best Care Anywhere* (currently in its third edition). The book chronicles the quality transformation of the Veterans Health Administration during the 1990s and applies its lessons to the broader U.S. health care system.

Longman received a BA in philosophy from Oberlin College.

Col. Lucretia M. McClenney, USA (ret.)

Appointed by House Minority Leader Nancy Pelosi

Lucretia McClenney is a consultant with the Department of Defense Vietnam War Commemoration Office and Executive Coach with the Brookings Institute Executive Education Program. Previously she served as director of the Department of Veterans Affairs Center for Minority Veterans. As director, she served as the principal advisor to the Secretary of Veterans Affairs on policies and programs affecting minority veterans. Prior to her appointment, she served as special assistant to the assistant secretary for policy, planning, and preparedness, Department of Veterans Affairs (VA). She led the department’s emergency exercise planning, training, and evaluation program, and served as liaison to other government agencies. She has served on numerous working groups to include the congressionally mandated National Commission on VA Nursing, Task Force on Employment of Women at VA, and as the Secretary

COMMISSION ON CARE FINAL REPORT

of Veterans Affairs' representative on the American Red Cross Board of Governors and Disaster and Chapter Services Committee.

Serving 30 years in the Army, McClenney retired as a colonel in November 2001. She served in various medical treatment facilities and on staffs worldwide serving as director, population health integration team, TRICARE management activity; chief nurse, European regional medical command and deputy commander for nursing, Landstuhl Regional Medical Command; deputy commander for nursing, Moncrief Army Community Hospital, Fort Jackson, South Carolina; assistant deputy for human resources, Office Of The Assistant Secretary Of The Army for Manpower and Reserve Affairs, the Pentagon; chief ambulatory nursing, Walter Reed Army Medical Center; senior policy analyst, Office of the Secretary of Defense (Health Affairs), The Pentagon; and member of the President's National Health Care Reform Task Force.

McClenney's military and civilian awards/decorations include the Legion of Merit (two oak leaf clusters), Defense Meritorious Service Medal, Meritorious Service Medal (seven oak leaf clusters), Army Commendation Medal (two oak leaf clusters), Navy Commendation Medal, Army Achievement Medal, Army Good Conduct Medal, the Army Staff Identification Badge, Office of the Secretary of Defense Staff Identification Badge, the coveted "9A" designator, in recognition of numerous achievements at the pinnacle of nursing excellence, and The Outstanding Civilian Service Medal for her significant contribution to the mission of the United States Army and Department of Defense in assisting with the production of the book, *For Children of Valor – Arlington National Cemetery*. Her professional affiliations include the Association of Military Surgeons of the United States, Sigma Theta Tau, National Nursing Honor Society, Alpha Kappa Alpha Sorority, Inc., Top Ladies of Distinction, Inc., The ROCKS, Inc., the Order of Military Medical Merit, Past President, Federal Health Care Executives Interagency Institute Alumni Association, and former Board Member of the Bon Secours Health Care System and Chair, Quality Committee.

She is a graduate of the Command and General Staff College and the United States Army War College Fellowship Program at George Washington University, Washington, DC. She is also a graduate of the Johnson & Johnson-Wharton's Fellows Program in Management for Nurse Executives, Wharton School of Business, University of Pennsylvania; Federal Health Care Executives Interagency Institute at George Washington University, Washington, DC; Leadership VA 2004; and Brookings Institute Executive Fellowship Program. She received a BSN from Murray State University and an MS in psychiatric/mental health nursing from Catholic University.

Capt. Darin S. Selnick, USAF (ret.)

Appointed by Speaker of the House John Boehner

Darin Selnick is an independent consultant who provides a variety of services to organizations in the areas of government and community relations, business development, and veterans' issues. He is currently the senior veterans affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He also volunteers his time as Chairman of the West Los Angeles Veterans Home Support Foundation and as the Vice President of Development for the GI Film Festival.

From 2001–2009, Selnick was an appointee at the Department of Veteran Affairs. From 2004–2009 he served as the director of the center for faith-based and community initiatives. In this role he was responsible for the management and operations of the Center and was the VA liaison to the White House Office of faith-based and community initiatives. From 2001–2004 he served as Special Assistant to the Secretary and Associate Dean, VA Learning University. In this role he was responsible for providing program and operational oversight of VA Learning University.

Selnick is a retired Air Force officer who attained the rank of Captain. He has been very active in veterans' issues and joined the Jewish War Veterans in 1994. Since that time he has taken various leadership positions and is the past department commander of the Department of California. Mr. Selnick is also a member of the American Legion, AMVETS, Air Force Association, and National Association of Uniformed Services.

Darin Selnick currently serves as senior veterans' affairs advisor for Concerned Veterans for America and served as executive director of the Fixing Veterans Health Care Bipartisan Taskforce. He lives in Oceanside, CA. Selnick is retired from the U.S. Air Force. He received a BS in health science from California State University, Northridge and an MA in political science/public management from Midwestern State University.

Lt. Gen. Martin Steele, USMC (ret.)

Appointed by Senate Majority Leader Mitch McConnell

Martin Steele enlisted in the Marine Corps in January 1965 and rose from private to three-star general, culminating his military career in August 1999 as the deputy chief of staff for plans, policies, and operations at Headquarters, U.S. Marine Corps, in Washington, DC. A decorated combat veteran with 34½ years of service, he is a recognized expert in the integration of all elements of national power (diplomatic, economic, informational, and military) with strategic military war plans and has served as an executive strategic planner/policy director in multiple theaters across Asia. His extraordinary career was chronicled as one of three principals in the award winning military biography, *Boys of '67*, by Charles Jones.

Upon his retirement from active duty in 1999, he served as president and CEO of the Intrepid Sea-Air-Space Museum in New York City. Currently, Steele serves as The Associate Vice President for Veterans Partnerships, the Executive Director, Military Partnerships, and Co-chair of the Veterans Reintegration Steering Committee at the University of South Florida in Tampa, Florida. Additionally, Steele is the chairman and CEO of Steele Partners, Inc., a strategic advisory and leadership consulting company. He has led a philanthropic transition program assisting exiting Marines into private-sector jobs throughout the country, at no cost to the Marine participants, the Marine Corps, or the companies that provide employment opportunities.

Steele serves proudly on several boards across the country. He is currently the Chairman of the Board, Marine Corps Scholarship Foundation. He was appointed to the Board of Directors of Florida is for Veterans, Inc., a not for profit, state legislated organization designed to assist both Veterans and businesses throughout Florida in not only hiring Veterans but also developing entrepreneurship programs designed for veterans. He is a member of Fisher House Foundation;

COMMISSION ON CARE FINAL REPORT

chairman of the advisory committee, Stability Institute; advisory committee member, Call of Duty Endowment; advisory board member, Stay in Step Foundation; advisory council member, Operation Helping Hand; member, Veterans Advantage; board member, University of Arkansas Veterans Resource and Information Center; and advisory committee member, Jesse Lewis Choose Love Movement.

Steele is a graduate of the University of Arkansas where he obtained a bachelor's degree in history and was recognized as a distinguished graduate of the Fulbright College of Arts and Sciences. He is a recipient of the 2013 Arkansas Alumni Award Citation of Distinguished Alumni, which recognizes exceptional professional and personal achievement and extraordinary distinction in a chosen field. He also holds master's degrees from Central Michigan University, Salve Regina College, and Naval War College.

Charlene M. Taylor

Appointed by House Minority Leader Nancy Pelosi

Charlene Taylor joined Kaiser Permanente in 1997 as the director of specialty services for the Permanente Medical Group at South Sacramento. In 2002 she became the service director for Kaiser Foundation Hospitals, responsible for perioperative and perinatal services at South Sacramento. In 2008, she was promoted to chief nursing officer at the Sacramento Medical Center where she was responsible for a 287-bed tertiary acute care hospital that conducted more than 11,000 operations per year. There, she oversaw 800 full-time employees and a budget of \$150 million. Taylor was promoted to chief operating officer in 2010 and retired from Kaiser Permanente in 2013.

Before working for Kaiser Permanente, Taylor served as assistant hospital administrator for Sutter Health at the Sutter Amador Hospital from 1988 to 1997. She is a member of the Veterans of Foreign Wars, Reserve Officers Association, and the Society of Air Force Nurses.

Taylor's patriotic and adventurous nature led her to join the Air Force as a reserve officer at the age of 40, rising to the rank of Lieutenant Colonel. She was commissioned as a Captain in the United States Air Force (Reserve Command) in October 1993, earning her flight nurse wings in 1994. She subsequently was selected to be a flight nurse instructor followed by a promotion to evaluator status. Her last squadron assignment was that of chief nurse at the 349 AMDS, Travis Air Force Base.

In addition to years of experience conducting aeromedical evacuation missions throughout the world, Taylor was activated in support of Operation Enduring Freedom from March 2003 to March 2004. In January 2005 she was selected to be the chief nurse of the 379th Expeditionary Aeromedical Squadron in support of Operation Iraqi Freedom. While transporting the injured out of Mosul, Iraq in a C-130, the aircraft took enemy fire, landing without casualties. Due to the demands of her civilian position, Taylor transferred to inactive status in the Air Force Reserve Command. Taylor is the recipient of two Meritorious Service medals, Expert Marksmanship (2), and multiple other medals.

Taylor currently serves on the Veterans Board. In 2012 she was appointed to the Board by Gov. Jerry Brown and approved by the Senate. She became chair in 2014 and continues to serve

in that role. The California Veterans Board serves as an advocate for veterans affairs, identifying needs and working to ensure and enhance the rights and benefits of California veterans and their dependents.

Taylor is a diploma nurse graduate from the Kaiser Foundation School of Nursing. She continued her education receiving a BSN from the State University of New York in Albany, New York. She earned a master's degree in nursing administration from the University of California, San Francisco.

Taylor lives in Elk Grove, CA.

Marshall W. Webster, MD

Appointed by Senate Minority Leader Harry Reid

Marshall Webster is a senior vice president of the University of Pittsburgh Medical Center (UPMC), and a distinguished service professor of surgery at the University of Pittsburgh. A graduate of Penn State University and the Johns Hopkins Medical School, he trained in surgery at the University of Pittsburgh, and subsequently served 2 years as a surgeon on active duty in the U.S. Navy.

Webster returned to the University of Pittsburgh as a faculty vascular surgeon, including initially, a part-time attending staff position at the Pittsburgh VA Medical Center for 3 years. He has held the Mark M. Ravitch Chair in Surgery, and has had a long academic career of clinical practice, research, and service in varied administrative leadership roles. From 2002–2012, he was an executive vice president of UPMC, president of UPMC's physician services division, and president of the University of Pittsburgh Physicians, the clinical practice plan of the university faculty.

His current focus is primarily strategic development: building clinical relationships and care models throughout the region with a large number of community hospitals and providers. Webster has oversight of UPMC's graduate medical education program, which sponsors a substantial number of resident rotations at the Pittsburgh VA Medical Center. He recently served for 2 years as the interim chair of the Department of Anesthesiology at UPMC. He has had a long-standing interest in patient safety and quality initiatives, and recently completed a 6-year term on the board of the Pennsylvania Patient Safety Authority.

COMMISSION ON CARE FINAL REPORT

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX K: COMMISSION STAFF

Susan M. Webman, Esq.
Executive Director

Michael Bargmann	Program Analyst
Robert Burke, PhD	Program Analyst
Donald Cicotte	Program Analyst
Pauline Cilladi-Rehrer	DFO
John Clinton	Staff Assistant
Monica Cummins	Program Analyst, ADFO
Christopher Danns	Program Analyst
Stephen Dillard	Program Analyst, ADFO
Susan Edgerton	Program Analyst
Beth Engiles	Program Analyst
Sharon Gilles	Program Analyst, DFO
Wilmya Goldsberry	Program Analyst
John Goodrich	Executive Officer, DFO
Sherri Hans, PhD	Program Analyst
Daniel Huck	Program Analyst
Ralph Ibson, Esq.	Program Analyst
Wendy J. LaRue, PhD	Editor-in-Chief
Gideon Lukens, PhD	Economist
Sonia Mastrogiuseppe	Staff Assistant
Jennifer E. McKinney	Document Specialist
Osita Osagbue	Program Analyst
Bernadette Philpot	Staff Assistant
Patrick Ryan, Esq.	Program Analyst
Jamie Taber, PhD	Economist
SaKeithia Taylor	Staff Assistant
Linda (Yvonne) Williams	Staff Assistant

DFO – Designated Federal Officer

ADFO – Assistant Designated Federal Officer

COMMISSION ON CARE FINAL REPORT

THIS PAGE INTENTIONALLY LEFT BLANK

APPENDIX L: ACRONYM LIST

ACRONYM	DEFINITION
ACA	Affordable Care Act
ACHE	American College of Healthcare Executives
APRN	Advanced Practice Registered Nurse
BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CARES	Capital Asset Realignment for Enhanced Services
CDS	Community Delivered Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veterans Affairs
CITC	Care in the Community
CMD	Chief Medical Director
CMIO	Chief Medical Information Officer
CMOP	Consolidated Mail Outpatient Pharmacy
COTS	Commercial Off-The-Shelf
CPRC	Clinical Product Review Committee
CPRS	Computerized Patient Record System
CVA	Concerned Veterans for America
CVCS	Chief of VHA Care System
DAV	Disabled American Veterans
DEPSECVA	Deputy Secretary, Department of Veterans Affairs
DHP	Digital Health Platform
DM&S	Department of Medicine and Surgery
DoD	Department of Defense
DUSH	Deputy Under Secretary for Health
ECF	Executive Career Fields
EES	Employee Education System
EEO	Equal Employment Opportunity

COMMISSION ON CARE FINAL REPORT

ACRONYM	DEFINITION
EHCPM	Enrollee Health Care Projection Model
eHMP	Enterprise Health Management Platform
EHR	Electronic Health Record
FFS	Fee-for-Service
FY	Fiscal Year
GAO	Government Accountability Office
GHATP	Graduate Health Administration Training Program
GUI	Graphic User Interface
HCD	Human-Centered Design
HEC	Healthcare Executive Council
HPDM	High Performance Development Model
HR	Human Resources
HRA	Human Resources and Administration
HSC	Health Service Category
HTM	Healthcare Talent Management
IAVA	Iraq and Afghanistan Veterans of America
IDIQ	Indefinite Delivery/Indefinite Quantity
IDN	Integrated Delivery Network
IDP	Individual Development Plan
IT	Information Technology
JC	Joint Commission
JEC	Joint Executive Committee
JLV	Joint Legacy Viewer
MSA	Medical Support Assistant
MTF	Military Treatment Facility
NAS	National Academy of Sciences
NCEHC	National Center for Ethics in Health Care
NCOD	National Center for Organization Development
NLC	National Leadership Council
NVTC	Northern Virginia Technology Council
OAA	Office of Academic Affiliations

ACRONYM	DEFINITION
OEF	Operation Enduring Freedom
OGC	Office of General Counsel
OI&T	Office of Information and Technology
OIF	Operation Iraqi Freedom
OMB	Office of Management and Budget
ONC	Office of the National Coordinator
OND	Operation New Dawn
OPM	Office of Personnel Management
OTH	Other Than Honorable (Discharge)
PACT	Patient Aligned Care Team
PC3	Patient-Centered Community Care
PG	Priority Group
PHS	U.S. Public Health Service
PO	Program Office
PTSD	Posttraumatic Stress Disorder
QUERI	Quality Enhancement Research Initiative
RCLF	Relevant Civilian Labor Force
RIF	Reduction in Force
SCI	Spinal Cord Injury
SECVA	Secretary, Department of Veterans Affairs
SE	Senior Executive
SES	Senior Executive Service
SHEP	Survey of Healthcare Experiences of Patients
TBI	Traumatic Brain Injury
TMS	Talent Management System
USH	Under Secretary for Health
VA	U.S. Department of Veterans Affairs
VACAA	Veterans Access, Choice, and Accountability Act of 2014
VACI	VA Center for Innovation
VACO	VA Central Office
VAEB	VA Executive Board

COMMISSION ON CARE FINAL REPORT

ACRONYM	DEFINITION
VAMC	VA Medical Center
VERC	Veterans Engineering Resource Center
VFW	Veterans of Foreign Wars of the U.S.
VHA	Veterans Health Administration
VHACO	VHA Central Office
VISN	Veterans Integrated Service Network
VSO	Veterans Service Organization
WWP	Wounded Warrior Project



Owner: Shulkin, David J., MD </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: LCPC Questions.docx
Last Modified: Wed Feb 22 18:05:33 CST 2017

QUESTIONS ABOUT LICENSED PROFESSIONAL COUNSELORS IN THE VA

1. How many Licensed Professional Counselors have been hired by the VA since the development of the qualification standards in 2010?
2. Of those hired, please provide the total number by GS rank.
3. How many LPMHC hold Supervisory positions in the VA?
4. How many stations have included LPMHC on their Leadership Boards?
5. How many LPMHC currently sit on the Professional Standards Board? How many have been on this board in the past?
6. Why is the LPMHC and LMFT PSB led by a Psychologist, and explain why neither board has ever met standards for PSB as described in VHA Handbook 5005?
7. Why does the LPMHC series have to hold a Supervisory position in order to be promoted to GS-12. Why aren't LPMHC allowed to promote to GS-12 by specialties as is done with Social Workers.
8. How many LPC's were in the VA, doing clinical work under different titles (Readjustment Counseling Therapist, Addictions Therapist) prior to the implementation of the qualification standards? (There was an action item about this...so they know.. I have the action item)
9. How many of these LPC's remain in clinical positions, performing clinical duties as Title 5 employees under the same titles held prior to the implementation of the qualification standards?
10. The VA has admitted to hire of LPC's prior to the development of the qualification standards, simply under other job titles. These hires were made with position vacancies requesting Licensure preferred.
11. How do you explain the VA billing for, verifying licensure of, requiring NPI's and VETPRO for these providers that were hired prior to the development of the qualification standards?
12. How do you justify the continued use of Licensed providers in clinical positions, with Position Descriptions that match the duties of the LPMHC performing these duties under Title 5 (Non-Clinical) positions (Readjustment Counseling Therapist, Addiction Therapist etc)? Title 5 positions are not clinical.
13. How do you justify the decision of the VA to implement an overly restrictive qualification standard (CACREP) and not offer any grandfathering to clinicians who were already employed by the VA (as DoD and Tricare did)? Psychology and Social Work were grandfathered.
14. How do you justify the decision of the VA to implement overly restrictive qualification standard (CACREP), without grandfathering, knowing that this restriction would disqualify a large majority of Professional Counselors, a lot of them Veterans, myself included.
15. How do you justify the decision of the VA to implement an overly restrictive qualification standard (CACREP), without grandfathering, while knowing that the CACREP degree required (60 hour Clinical Mental Health Counseling) was not available in most States, and specifically was not available near military installations for those people who are older. (16 programs nationwide in 1998 that would qualify you for LPC Licensure, some States had a couple CACREP Programs, most States did not have any).
16. How do you justify the continued lack of vacancy position openings in the VA for LPMHCs?
17. How do you justify leadership positions excluding LPMHC and LMFT from position vacancies?
18. Who was on the Board that determined the overly restrictive qualification standard?
19. What empirical data was used to come to the decision to use CACREP as the ONLY qualification without grandfather?
20. Please explain why LPC's who are under other job titles have been denied request to join the list serve for LPMHC's?
21. Please explain why CACREP was provided a \$500,000 contract, under full and open competition after exclusion of sources: Number of offers received ONE. To write standards for the "Counselor

National Emergency Preparedness Language” that was later used to justify the restrictive qualification standard within the VA, DoD and Tricare? (Notice this contract was awarded in September 2006...just before the passage of the bill recognizing LPC's in December 2006. Also, note...EXTENT COMPETED:

“Full and Open Competition after Exclusion of Sources

This contract was commissioned to write the standards for “Counselor National Emergency Preparedness Language

22. Please explain why the PSB for LPMHC utilized Non-CACREP LPC's to Board the few LPMHCs that qualified into the VA, then told them that they did not qualify to Board?

23. Please explain why programs for LPMHC internships have not been established or offered at VA's?

24. Please explain how the VA justifies this negatively impacting Veterans who received their education in and around the military bases at which they were stationed?

25. Please explain why open positions for LPMHC also state that Social Workers and Psychologists are qualified for the position? However, the reverse is not true.

26. How many organic LPMHC's (not dually licensed) sit on Leadership Boards to include National Representation?

27. Of those, how many are Veterans?

Owner: Shulkin, David J., MD </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: Letter to Shulkin.docx
Last Modified: Wed Feb 22 18:05:33 CST 2017

February 21, 2017

Re: Licensed Professional Mental Health Counselors at Veterans Affairs

Dear Dr. Shulkin:

I recently attended the American Federation of Government Employees (AFGE) legislative conference. I was able to briefly discuss my concerns with you regarding the problems Licensed Professional Mental Health Counselors (LPMHC) experience while working for Veterans Affairs.

Public Law 109-461, which was enacted December 22, 2006, explicitly recognized both "licensed professional mental health counselors" and "marriage and family therapists" as mental health providers within Veterans Affairs. On September 28, 2010, the Department of Veterans Affairs (VA) released a set of qualification standards for licensed professional mental health counselor (LPMHC) positions, as well as for marriage and family therapist positions. Prior to the adoption of the new standards, counselors were typically eligible only for "rehabilitation counseling therapist" positions, at a maximum General Service (GS) level of 11. At this level, counselors were not allowed to work in supervisory positions. Although LPMHC's have qualification standards, there are still limited opportunities for advancement, training, transferability, or promotion. Although hundreds of employees with these credentials have been working in the VA under different position descriptions, they have not been transitioned into an LPMHC position. This may be because the VA has made it a local decision to transition the employee. Or, the National standards still do not recognize these employees because they may not have attended a school that was accredited. The accreditation was not available to many of these employees when they went to school. The accreditation is anecdotal according to the Council for Accreditation of Counseling & Related Educational Programs (CACREP) own website. The Department of Defense and TRICARE have recognized these providers and grandfathered them into a provider status. The VA is the only employer that does not recognize LPMHC's that did not attend a CACREP accredited school. The VA has also grandfathered Social Workers and Psychologists prior to having accreditation in their professions. We are asking for a grandfather clause for any provider that is State licensed or eligible. We are asking that the VA transition any employee that is eligible to work in that position automatically that chooses to do so.

Many of the providers that do not qualify for the LPMHC position are working as Addiction Therapists, Readjustment Counselors, or Psychology Technicians to name a few. These are Title 5 positions and are considered "non-clinical". These are direct line staff that have clinical duties within these professions to provide specialized care to Veterans. We ask that if the VA is unwilling to grandfather LPMHC's, they instead bring these positions to a Hybrid 38 status and GS-11 pay scale to reflect their knowledge, skills, and abilities.

The Commission on Care report recommendation #2 stated that the VA should "enhance clinical operations through more effective use of providers and other health professions, and improved data collection and management". This would be an effective way to utilize the providers already in place and at their disposal, increase Veterans access to care, and decrease workload on higher level providers. The RAND report which is a survey of 522 psychiatrists, psychologists, and licensed clinical social workers found that 13% met the study's criteria for "cultural competency" in the military, only 6% had ever served in the military. According to the RAND report, LPMHC's scored the highest for familiarity of evidenced-based practices for PTSD and combat-related mental health issues. Many of the LPMHC's attended their schooling on military installations where CACREP was not available, therefore excluding them from LPMHC positions.

I would like to have the opportunity to discuss this matter in more detail. I have attached 25 questions I would like to have answered by the Veterans Affairs. I have tried to get the answers to these questions, but I was met with hostility. This is a brief synopsis of a larger systemic problem that negatively impacts Veteran care and employee morale. Please contact me through my personal information listed below. I appreciate any assistance you can provide.

Regards,

(b)(6)

(b)(6)

(b)(6)

(b)(6)

@gmail.com

Owner: Shulkin, David J., MD </o=va/ou=exchange administrative group (fydibohf23spdl)
/cn=recipients/cn=(b)(6)
Filename: RAND_RR806.pdf
Last Modified: Wed Feb 22 18:05:33 CST 2017

Ready to Serve

**Community-Based Provider Capacity to Deliver
Culturally Competent, Quality Mental Health Care
to Veterans and Their Families**

Terri Tanielian

Coreen Farris

Caroline Epley

Carrie M. Farmer

Eric Robinson

Charles C. Engel

Michael William Robbins

Lisa H. Jaycox



For more information on this publication, visit www.rand.org/t/rr806

Library of Congress Cataloging-in-Publication Data is available for this publication.

ISBN: 978-0-8330-8768-3

Published by the RAND Corporation, Santa Monica, Calif.

© Copyright 2014 RAND Corporation

RAND® is a registered trademark.

Cover design by Pete Soriano

Limited Print and Electronic Distribution Rights

This document and trademark(s) contained herein are protected by law. This representation of RAND intellectual property is provided for noncommercial use only. Unauthorized posting of this publication online is prohibited. Permission is given to duplicate this document for personal use only, as long as it is unaltered and complete. Permission is required from RAND to reproduce, or reuse in another form, any of its research documents for commercial use. For information on reprint and linking permissions, please visit www.rand.org/pubs/permissions.html.

The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.

Support RAND

Make a tax-deductible charitable contribution at
www.rand.org/giving/contribute

www.rand.org

OVERVIEW

Addressing the mental health needs of military service members, veterans, and their families is a national priority and the focus of many efforts at the federal, state, and local levels.¹ Over the past decade, several studies have documented the extent of the need for mental health treatment among this population, and billions of dollars have been invested to expand the capacity of the systems designed to support veterans and their families at multiple levels and across sectors.² The White House and Congress have been working directly with the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to ensure that mental health providers are hired and programs are disseminated to address mental health needs within the veteran community,³ but concerns remain about whether the capacity of these systems is sufficient to meet the demand.⁴ Recently, new federal legislation was enacted to increase VA beneficiary access to private, civilian-sector care.⁵ Although the opportunity to receive care in the community existed in the past, the new law will likely greatly expand the rate at which eligible veterans seek care outside of the VA. This raises a new concern about the capacity of the civilian mental health service sector to meet the needs of veterans and their families.

While many veterans already receive care from private providers and community-based organizations,⁶ little is known about the extent to which veterans and their families receiving such care are getting high-quality care, are benefiting from that care, and are satisfied with their providers. There have been multiple efforts at the national, state, and community levels to promote awareness of military and veteran-related issues among community-based mental health providers, including the development of specialized training curricula and certification programs. With the intent of improving providers' understanding of and skills for addressing needs in the population, these training opportunities vary from short webinars to weeklong courses to intense, certificate- or degree-awarding programs.⁷

In addition, nongovernmental organizations have pursued the formation of specialized networks, such as Give An Hour and the Star Behavioral Health Provider network,⁸ and the opening of new community-based clinics dedicated to treating military service members, veterans, and their families.⁹ To date, however, little is known about the capacity and performance of these networks and specialized clinics.

Monitoring access to and quality of mental health care for service members, veterans, and their families is important for ensuring that their needs are met effectively. A recent Institute of Medicine (IOM) study highlighted the challenges that both DoD and the VA face in monitoring such issues within their own systems—including the facilities they own and operate—and noted that their visibility into the “outside” systems where the population also receives care is even more limited.¹⁰

RAND's study was designed to assess the potential performance of the system of care for service members, veterans, and their families, with a particular focus on community-based, civilian providers. This study specifically addresses the potential readiness of mental health providers working in community settings to deliver culturally competent, high-quality care to service members, veterans, and their families. This study builds upon previous studies examining similar issues for providers working within VA and DoD settings, as well as two studies of civilian providers.¹¹ We explore provider capabilities, attitudes, and behaviors as they relate to providing high-quality and culturally appropriate care, and we examine what factors may predict their readiness to deliver such care. Understanding the skills and training of mental health providers from non-DoD and non-VA settings who are potentially delivering care to service members, veterans, and families will help inform expectations about what types of care these beneficiaries may experience within civilian settings and the extent to which that care is of a high quality. Such information can also help direct future training efforts designed to ensure that providers are ready, capable, and willing to address the mental health needs of our nations' veterans and their families. The following sections provide additional information about our approach, findings, and the implications from this research.

SURVEY OF MENTAL HEALTH PROVIDERS

Improving mental health outcomes for veterans and their families requires both *access to care* and receipt of *high-quality care*.¹² The overall goal of this study was to understand the readiness of community-based providers to deliver high-quality mental health care to veterans and their families once they access such care. The IOM has defined *high-quality care* as care that has been demonstrated as effective (i.e., evidence-based), safe, patient-centered, timely, efficient, and equitable.¹³ Using this definition as a reference point for our study, we conceptualize the readiness of providers to deliver veteran-friendly, high-quality mental health care as having two main components (see Figure 1). The first is *cultural competency*, or the degree to which providers are sensitive to the unique needs and relevant issues of concern within the veteran population. This cultural sensitivity and competency can facilitate providers’ ability to deliver patient-centered care and develop an effective therapeutic rapport.¹⁴ The second main component of our provider readiness definition is the degree to which community-based providers have the *capacity and inclination to deliver clinically appropriate, evidence-based care*. In particular, the survey focused on evidence-based care related to major depressive disorder (MDD) and posttraumatic stress disorder (PTSD). These conditions were highlighted because of their prevalence among the recently returned veteran population and their association with experiences common to military deployments. Each concept is defined in further detail in subsequent sections.

To assess provider readiness to deliver high-quality, culturally competent care to service members, veterans, and their families, we employed a web-based survey of mental health providers. The sections below outline the methods used to sample providers and describe the survey measures used to assess the relevant components of readiness. We also gathered data on the characteristics of responding providers, their clinical caseloads, and their practice settings to explore how these factors relate to overall readiness.

Sampling

To identify and survey mental health providers working in community-based settings, we relied upon existing panels of health care providers maintained through GfK Custom Research and two of their vendors. Practicing mental health

professionals in the panels were sent emails inviting them to participate, and participants were provided with tokens of appreciation through the traditional means of providing incentives in their host panels (i.e., awarded points based on the anticipated respondent burden). Specifically, psychiatrists were recruited from an existing GfK provider panel originally drawn from the American Medical Association membership list and later augmented to refresh and expand the panel. Psychologists were recruited from an existing allied health care provider panel maintained by Research Now. Social workers and licensed professional counselors were recruited from existing panels maintained by Research Now and a separate panel maintained by EMI. The demographic and practice characteristics of all mental health providers within these panels were not available and the degree to which their panel membership is representative of each provider population is unknown. GfK emailed potentially eligible participants a standard recruitment email asking for their participation in a 30-minute survey about their mental health practice.

The web-based survey was fielded only for the period of time required to reach the target numbers of each provider

Abbreviations

CBT	Cognitive Behavioral Therapy
CPG	clinical practice guideline
CPT	Cognitive Processing Therapy
DO	doctor of osteopathic medicine
DoD	Department of Defense
EAP	Employee Assistance Program
EBP	evidence-based psychotherapy
EMDR	Eye Movement Desensitization and Reprocessing
IPT	Interpersonal Therapy
IOM	Institute of Medicine
LCSW	licensed clinical social worker
LMHC	licensed mental health counselor
LPC	licensed professional counselor
MD	doctor of medicine
MDD	major depressive disorder
MCSW	master’s of clinical social work
ns	not significant
PE	Prolonged Exposure Therapy
PhD	doctor of philosophy
PsyD	doctor of psychology
PTSD	posttraumatic stress disorder
SIT	Stress Inoculation Therapy
VA	Department of Veterans Affairs
WRAIR	Walter Reed Army Institute for Research

Figure 1: Readiness for Veteran-Friendly, High-Quality Mental Health Care

type (target goal was 125 respondents in each provider group, to ensure sufficient sample size for detecting differences between provider groups). All target numbers were reached within three weeks. Responding providers were screened to ensure that they were

- trained and licensed as a professional provider of mental health services in their state
- working directly with patients/clients as part of their professional responsibilities
- one of the four provider types of interest
 - psychiatrist—doctor of medicine (MD) or doctor of osteopathic medicine (DO)
 - clinical psychologist—doctor of philosophy (PhD) or doctor of psychology (PsyD)
 - licensed clinical social worker (LCSW) or master's in clinical social work (MCSW)
 - master's-level licensed professional counselor (LPC) or licensed mental health counselor (LMHC).

Participants who indicated later in the survey that they were fully retired or not currently in practice were excluded. The study was determined to be exempt from human subjects review by the RAND Human Subjects Protection Committee. The topics of military and veteran mental health care, cultural competency, and evidence-based practice were not specifically identified in the recruitment email sent by GfK or in the introductory page of the survey; thus, the topic was not likely to influence the choice to participate or complete the full survey. As with all surveys conducted among convenience samples, it is difficult to understand the potential bias introduced by those choosing to participate in such panels and surveys compared to the full population of providers.

Measures

RAND researchers designed a web-based survey to collect information from mental health providers across several domains. For each of the two components of our

readiness concept, providers were asked about their knowledge, attitudes, and behaviors relevant to the concept. Where possible, survey items come from or were adapted from prior surveys of mental health professionals. Where necessary, RAND researchers developed new items for domains without published survey instruments. Table 1 provides an overview of the survey domains, their corresponding items, and information about how the items were used to characterize providers and inform the analysis. The following section briefly describes the measures used across the domains of interest. Readers interested in additional details about specific items, including psychometric properties and scoring criteria, where available, can reference the Appendix at http://www.rand.org/pubs/research_reports/RR806.html.

Provider Characteristics

In addition to asking respondents to indicate their provider type (e.g., social worker, psychologist), we gathered information on provider gender, years since most recent degree, whether they ever served in the armed forces,¹⁵ whether they had any close family members who served in the military, and if they ever worked in a military setting or in the VA (including training or fellowships).¹⁶ We also asked how providers spent their time across a series of activities, including conducting assessments, providing direct patient care (psychotherapy and medication management), receiving supervision or consultation from others, providing supervision to others, and other professional or administrative responsibilities such as research or teaching.¹⁷ In addition, we asked a series of questions about enrollment in provider networks that typically serve military and veteran populations, including TRICARE (the DoD insurance program for active component service members and their families, retirees and their families, as well as some eligible Guard and Reserve Component personnel and their families), Military OneSource (an Employee Assistance Program [EAP]–like program that employs some mental health providers to support DoD beneficiaries), and the new VA Patient Centered Community Care Contract (established for specialty providers).

Practice and Clinical Caseload Characteristics

To understand the context in which respondents practice, we assessed a number of features of their practice settings and their clinical caseloads. All questions in this section were structured

to assess caseloads, hours, and setting characteristics of the most recent typical work week.

We asked providers to report the size of their patient caseload in the most recent typical week, including patients seen in individual or family format as well as those seen in group settings. We gathered information about the proportion of patients by the locus of care, by age group, and by current diagnosis using categories from the Diagnostic and Statistical Manual—Version 5. We also asked respondents to estimate the proportion of their current caseload that: were current members of the military, were former members of the military (veterans), or were family members of current or former members of the military.

To understand the types of settings and facilities our respondents were working within, we assessed the percentage of patient care hours that were spent in different physical locations (e.g., solo office practice, VA facility). Using responses to the setting and insurance items, we classified providers into one of three groups: DoD/VA providers (those providers spending any patient care time in a DoD or VA health care setting), non-DoD/VA providers who accept TRICARE, and all other providers (i.e., those that do not spend any time in a DoD or VA facility or accept TRICARE).

We also gathered the ZIP code of the facility in which the provider saw the greatest number of patients in the most recent typical work week. Using the ZIP code information for the provider's setting, we calculated the distance between their setting and the nearest DoD or VA health care facility to create a proximity to DoD/VA variable. With this continuous variable, we also created a categorical variable for analyses: within ten miles or 11 or more miles away.¹⁸ Similarly, we used the ZIP code of the provider's setting to determine if they worked in an urban or rural setting.¹⁹

Assessment Behaviors

To understand the frequency of routine screening practices employed by respondents, we asked providers to report how often, using a 5-point scale (never, seldom, occasionally, often, and always), they screened patients: (1) to determine if they are current or former members of the Armed Forces or a family member of such a person; (2) for history of any traumatic events, including those experienced during military service, and (3) about stressors related to military life or being a veteran.

Table 1: Overview of Mental Health Provider Survey Domains

Domain	Types of Items	Source and Use
Provider characteristics	<ul style="list-style-type: none"> • Training (MD, DO, PhD, LCSW, MCSW, LMHC, LPC) • Gender • Years in practice/experience • Primary therapeutic orientation • DoD or VA work experience • Relationships with current/former members of Armed Forces 	These items were adapted from prior VA, U.S. Army, and American Psychiatric Association studies. They are used to characterize the respondents and examine predictors of practice behaviors and provider attitudes.
Practice and caseload characteristics	<ul style="list-style-type: none"> • Caseload size • Distribution of caseload by age, diagnosis, insurance type, and military status • Setting (outpatient/inpatient/partial, solo/group, public/private) • Participation in networks that serve military members and veterans 	These items were adapted from prior American Psychiatric Association and U.S. Army surveys of mental health providers. They are included to help describe the practice setting and typical patient caseload served by respondents. The data are used to characterize the respondents and examine predictors of high-quality mental health care.
Assessment behaviors	<ul style="list-style-type: none"> • Employment of routine screening approaches, including taking a military history and assessing suicide risk and comorbid problems such as pain and sleep disturbances • Use of validated screening or interview instruments • Frequency of engaging other clinicians and family members 	These items were adapted from prior surveys used by the Center for Deployment Psychology and the U.S. Army. The data are used to understand provider assessment practices.
Military cultural competency	<ul style="list-style-type: none"> • Knowledge of military and veteran culture • Comfort working with military service members and veterans • Self-reported proficiency in treating military service members and veterans • Participation in military/veteran culture training 	These items were adapted from prior surveys used by the Center for Deployment Psychology and the VA. The data will describe respondents' knowledge of military and veteran culture. The data are also used to define analytic groups of providers with respect to their military cultural competency.
Training to deliver evidence-based care	<ul style="list-style-type: none"> • Training and supervision in evidence-based psychotherapies (EBPs) 	These items were adapted from other surveys used by the U.S. Army and assess receipt of training and supervision in EBPs for PTSD and MDD.
Comfort with treatment approaches and military/veteran populations	<ul style="list-style-type: none"> • Comfort treating depression • Comfort treating PTSD • Comfort treating military members and veterans • Comfort addressing war-related stress • Comfort treating military family members 	These items were developed by RAND researchers for this study. The items provide descriptive information about the level of "comfort" among respondents in these areas. Some items are also used in the derivation of the military cultural competency variable.
Use of guideline-concordant care for PTSD and MDD	<ul style="list-style-type: none"> • Self-reported proportion of caseload treated with EBPs • Use of psychotherapeutic techniques consistent with EBPs 	These items were adapted from other surveys used by the U.S. Army, U.S. Air Force and RAND and assess use of EBPs recommended in civilian and DoD/VA practice guidelines
Attitudes toward practice guidelines	<ul style="list-style-type: none"> • Attitudes toward clinical practice guidelines (CPGs) and evidence-based medicine 	These items were adapted from an instrument developed for the New York State Psychiatric Association. The items ask providers to rate their attitudes toward using clinical guidelines and may help explain variation observed in use of guideline-concordant care for PTSD and MDD.
Prescribing practices	<ul style="list-style-type: none"> • Most common medications prescribed for PTSD and MDD 	This item was adapted from an Army study titled "Steps Up" and is a measure of guideline-concordant pharmacological treatment for PTSD and MDD. We examine the percentage of providers who prescribe appropriate medications for PTSD and MDD.

SOURCES: We used several instruments as references in developing this survey. All of these prior surveys were developed for other purposes, but provided relevant information and suggestions for items that would help us to assess use of guideline-concordant care, evidenced-based approaches, and routine practice behaviors. We also drew on items in other surveys used to assess the impact of military and veteran cultural awareness training on participants through the Center for Deployment Psychology (for example, the Star Behavioral Health Providers) programs to inform our items on knowledge/attitudes/awareness of military and veteran culture. It should be noted that the overwhelming majority of the items have been modified in some manner from our original references; that is, we changed scales, reference points (all patients versus "this" patient), and response items in an effort to tailor this survey to the specific issues and population for this study. More information about the surveys reviewed can be found in the Appendix.

Military Cultural Competency

To understand the degree to which providers were sensitive to military and veteran culture, we asked a series of questions designed to assess providers' knowledge and awareness of, and attitudes toward, military culture. We also assessed their perceived proficiency in working with military and veteran populations and exposure to prior training in military cultural competency. Figure 2 provides an overview of the concepts we used to define cultural competency for this study.

To assess knowledge and awareness of military and veteran culture, we asked providers to rate their level of familiarity (on a 5-point Likert scale) with U.S. military culture and practices. Similarly, we asked providers to indicate their level of comfort with respect to working with military service members and veterans, working with patients/clients with military or war-related stress, and working with family members of military service members or veterans.

Respondent proficiency in military and veteran culture was assessed via ten items that tapped self-reported perceptions of cultural competency in three different domains, cultural knowledge (three items), cultural sensitivity (one item), and cultural skill (six items). These items, modified from items on the Nurse Cultural Competence Scale,²⁰ asked respondents to read statements and agree or disagree on a 5-point scale. Training in military culture was assessed via one yes/no item that asked about receipt of formal training in military and veteran culture.

Using all of these items described above, we derived a military cultural competency score by scoring each item as described in Table 2. This overall measure of military cultural competency summed the continuous variables for a range of 0–22, and a cut-score of 15 or more points was defined as “high military cultural competency.”

Capacity to Deliver Evidence-Based Care

As highlighted earlier, provider capacity to deliver evidence-based care to patients may depend on several factors. For example, prior training in the delivery of evidence-based approaches may be one indicator that a provider has capacity to deliver high-quality care; however, it is also important to understand the degree to which they have or will use these techniques to address the mental health needs of veterans and their families when they access providers. Other factors, such as their beliefs or attitudes about such approaches, may affect their willingness to use the techniques. Thus, to understand provider capacity to deliver evidence-based care, we assessed several domains:

Figure 2: Concepts Related to Provider Military Cultural Competency



training in evidence-based approaches, use of such treatment in routine practice, attitudes toward practice guidelines, and other routine behaviors. These are described in Figure 3 and in the following sections.

Training in Evidence-Based Psychotherapies for PTSD and MDD

To assess provider capacity to deliver evidence-based psychotherapies (EBPs) for PTSD and MDD, we assessed whether providers: (a) held formal certification or intensive/advanced training and (b) had supervised professional practice in any of five psychotherapies specified as first-line therapies for PTSD and depression in VA/DoD CPGs (2009, 2010).²¹ Providers who had received training and supervision in at least one type of EBP were classified as “capable” of delivering evidence-based treatment for the given condition.

Use of Evidence-Based Treatment Approaches

A dichotomous variable was used to summarize providers' reliance on evidence-based treatment modalities. Each provider estimated the percentage of patients that they treated in the most recent typical work week with 16 different treatment approaches. Treatments ranged from well-validated approaches for treating PTSD (e.g., Prolonged Exposure Therapy [PE]) to general therapeutic techniques without strong efficacy find-

Table 2: Measures of Military Cultural Competency

Concept	Measure	Response Scale	# of Items	Operationalization
Knowledge and awareness	Level of familiarity with military and veteran culture	1–5 Likert scale (Completely unfamiliar– Extremely familiar)	8	1=Very familiar or Extremely familiar; 0 otherwise (0–8 range)
Comfort	Comfort level working with military veterans and their families	1–5 Likert scale (Not at all comfortable– Extremely comfortable)	3	1=Mostly comfortable or Extremely comfortable; 0 otherwise (0–3 range)
Skills	Self-reported proficiency	1–5 Likert scale (Strongly disagree–Strongly agree)	10	1=Agree or Strongly agree; 0 otherwise (0–10 range)
	Prior training in military culture	Yes/No	1	1=Yes; 0=No (0–1 range)

ings (e.g., supportive psychotherapy). Approaches categorized as evidence-based treatments included those for PTSD (PE, Cognitive Processing Therapy [CPT], Eye Movement Desensitization and Reprocessing [EMDR], and Stress Inoculation Training [SIT]), depression treatments (Cognitive Behavioral Therapy [CBT], Interpersonal Therapy [IPT], and Acceptance and Commitment Therapy), and two additional treatments with support for use with patients who had substance use disorders or borderline personality disorder (i.e., Motivational Interviewing, Dialectical Behavioral Therapy).²² Past-week evidence-based practice was dichotomized between providers who reported treating 75 percent or more of their patients with EBP and those who did not meet this threshold. This threshold creates an easily summarized estimate of the proportion of providers from which patients are reasonably certain to receive an evidence-based treatment.

Practice Behaviors Related to Use of Psychotherapy for PTSD

To assess providers' adherence to therapeutic techniques associated with three validated PTSD psychotherapies (PE, EMDR, CPT), we used a modified version of a session behavior scale used in a Walter Reed Army Institute for Research (WRAIR) study in 2013.²³ Two items assessed treatment techniques representative of PE, two items assessed techniques associated with CPT, and one item assessed a technique unique to EMDR. For this report, we summarize the proportion of providers who reported that they "often" or "always" use therapeutic techniques associated with at least one EBP approach for PTSD. Note that providers who do not see patients with PTSD reported instead on their likelihood of using each technique if they "were to treat patients with PTSD."

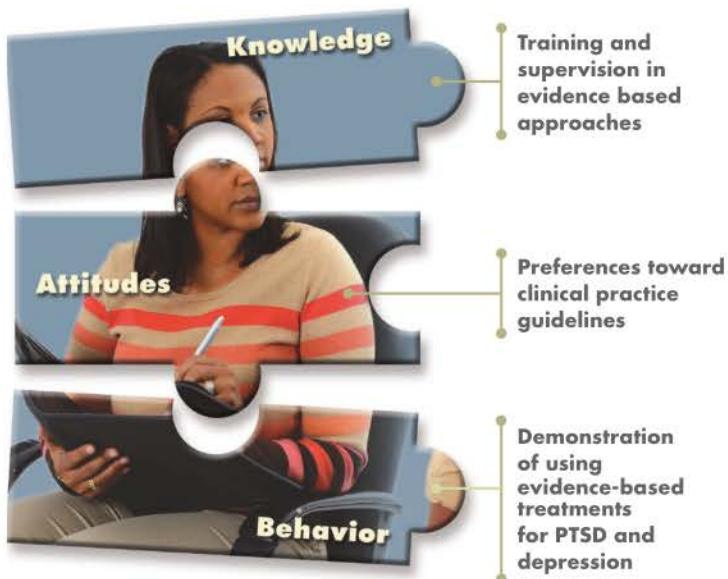
Practice Behaviors Related to Use of Psychotherapy for Depression

We used a modified version of the Psychotherapy Practice Scale to assess providers' adherence to the therapeutic techniques associated with two evidence-based approaches to depression treatment (CBT and IPT). The original scale prompted providers to consider a specific, randomly selected patient from their caseload with MDD. For ease of administration, these instructions were modified to ask providers who treat patients with depression to estimate the frequency with which they use nine distinct therapeutic techniques. Providers who do not see depressed patients were asked to estimate the likelihood that they would use each technique if they were to treat a patient with depression. Three items assessed treatment techniques representative of CBT, three assessed techniques associated with IPT, and three assessed common, but less well-supported, psychodynamic techniques. For this study, the full, 16-item Psychotherapy Practice Scale was reduced to nine items to reduce respondent burden.²⁴ For this report, we summarize the proportion of providers who reported that they "often" or "always" use the therapeutic techniques associated with either CBT or IPT with depressed patients. Note that providers who do not see patients with depression reported instead on their likelihood of using each technique if they "were to treat patients with depression."

Medication Management for PTSD and Depression

To assess adherence to evidence-based guidelines for psychopharmacologic treatment of PTSD and MDD,²⁵ prescribing providers listed the "two most common first-line psychopharmacologic treatments" they prescribe for patients with each condition. A list of 90 common psychoactive medications—including antidepressants, anxiolytics, sedative-hypnotics, psychostimulants, and opioid analgesics—was provided for

Figure 3: Concepts Related to Provider Capacity to Deliver Evidence-Based Care



respondents to select from. To meet our criteria for “evidence-based prescriptive practice,” respondents had to select at least one antidepressant from the list for depression *and* one selective serotonin reuptake inhibitor or prazosin for PTSD.

Attitudes Toward CPGs

CPGs provide recommendations designed to improve patient care. They are developed after a systematic review of the evidence and consideration of the harm and benefit associated with a given approach.²⁶ Although the intent is to ease provider burden by succinctly recommending best practices for a given condition, some providers see CPGs as overly rigid, oversimplified, and as a threat to their clinical independence. For this study, we included the 11-item CPG Attitudes Scale from a New York State Psychiatric Association study as a proxy for provider attitudes toward evidence-based medicine and validated treatments for PTSD and MDD.²⁷ In the descriptive analyses below, scale scores are dichotomized into those who, on average, “agree” or “strongly agree” with CPG supportive statements (labeled “above threshold”) and those who fall below this threshold. Attitudes toward CPGs are entered as a continuous variable in the regression analysis, that is, the mean of all 11 items.

Analysis

We performed analyses to describe the provider sample that generally fall into three types: (1) basic univariate analyses,

(2) bivariate comparisons across pairs of variables, and (3) logistic or linear regressions to assess the contribution of sets of predictors to key dependent variables. First, univariate statistics were calculated to provide an introductory understanding of the pattern responses. For instance, the mean and standard deviation of the CPG Attitude Scale were calculated.

To assess relationships across pairs of dichotomous and continuous variables, we used independent-sample t-tests. To assess relationships across pairs of categorical variables, we used chi-square analyses. Finally, logistic and linear regressions were used to assess the relationship between a binary outcome and multiple predictor variables simultaneously. These regressions identify which predictors (if any) are most influential with respect to a specific outcome variable after controlling for the effect of all other predictor variables in the model.

RESPONDENT CHARACTERISTICS

We recruited a total of 522 mental health care professionals to participate in the survey (Table 3). Respondents included roughly equal groups (by design) of psychiatrists ($n=128$), psychologists ($n=127$), social workers ($n=132$), and licensed counselors ($n=135$). The majority of participants across professions were female (60 percent) with some variation by profession (the majority of psychiatrists—77 percent—were male).²⁸ Respondents generally worked full time. In addition, participants reported seeing the majority of their patients (77 percent on average) in outpatient settings in the most recent typical work week, and smaller percentages of patients (17 percent on average) were seen in inpatient and other settings (5 percent), such as schools, correctional facilities, or partial day programs. On average, providers reported spending the majority of their professional hours (19 percent) in a solo office setting, followed by a group office setting (15 percent). The percentage of professional hours spent by setting did vary by provider type.

As described earlier, we created an indicator of provider affiliation relative to military and VA settings, as well as the TRICARE provider network. The first group included any provider who indicated seeing patients (any number of patients) currently in a DoD or VA setting ($n=61$). The second group included those providers who did not see any current patients in a DoD or VA setting, but who reported being affiliated with the TRICARE network ($n=135$). The final group reported neither of these military affiliations ($n=326$).

Prior Experience in the Military or in VA Settings

On average, 6 percent of respondents reported that they had served in the military.²⁹ Participating psychiatrists had the highest rates of military service, at 10 percent. More than one-third of respondents reported having family members in the armed forces. We note that it is not clear from our survey whether time spent in service was as a mental health provider or if individuals pursued their mental health care licensing following their military service.

Military and VA treatment settings each provide professional training opportunities for health care providers in the United States.³⁰ The VA in particular offers several clinical internship and fellowship opportunities for health care providers, including mental health professionals. We found that, overall, about one-third of respondents reported some experience working in some capacity (during training or in other roles) in either a military setting or in the Veterans Health Administration. There was some variation by provider type with regard to experience in military and VA settings, with

more psychiatrists reporting having worked in a military or VA setting (62.5 percent) compared to one-third of psychologists and one-fifth of social workers and licensed counselors. The average time that providers worked in military or VA settings was 4.5 years ($SD=6.06$). It should be noted that we asked about time spent in either a military or VA setting; however, these settings may differ in important ways with respect to the nature of the experience and training offered. In addition, for providers reporting having served or working in military or VA settings, their time spent in service or working in these facilities may have been in a different capacity than as a mental health provider. This is particularly true for licensed counselors who are traditionally not employed with VA health settings as mental health providers. Thus, some of these providers may have worked within military or VA settings as nonmedical counselors or in other capacities either before or after their licensing. Regardless of their professional designation within these settings; however, the providers are reporting having worked in such settings and as such likely had exposure to military and/or veteran patients and families.

Table 3: Respondent Demographic and Practice Characteristics

Respondents	All (n=522)	Psychiatrists (n=128)	Psychologists (n=127)	Social Workers (n=132)	Licensed Counselors (n=135)
Female	59.8%	22.7%	74%	80.3%	61.5%
Works full time	95.7%	98.4%	97.6%	94.7%	92.3%
Setting in which greatest number of patients seen	Solo office practice	Solo office practice	Solo office practice	"Other" setting	Group office practice
Solo office practice	18.4%	31.3%	22.8%	6.8%	13.3%
Group office practice	16.5%	15.6%	13.4%	9.8%	2.7%
Ever served in Armed Forces	6.1%	10.2%	4.7%	1.5%	8.2%
Has family in Armed Forces	38.1%	29.7%	44.9%	42.4%	35.6%
Ever worked in DoD or VA setting	34.9%	62.5%	34.7%	21.1%	22.2%
Primary setting is within ten miles of either VA or DoD	55.5%	53.9%	56.7%	59.4%	51.9%
Registered in TRICARE network	29.5%	37.5%	28.3%	27.2%	25.1%
Part of Military OneSource	5.2%	3.2%	3.2%	5.3%	8.9%
Registered in VA Veterans Patient Centered Community Care network	6.1%	5.5%	3.9%	6.8%	8.1%
Average number of years since completing training	18.0 years	26.2 years	17.0 years	16.6 years	13.9 years

Practice Settings and Proximity to Military or VA Facilities

Respondents reported working and seeing patients in a number of different settings. Figure 4 displays the percentage of professional hours that respondents reported spending in the most recent typical work week by clinical practice setting; Table 4 summarizes the percentage of patients seen by the locus of care (outpatient versus inpatient). Geographically, respondents reported working in practice locations across the continental United States and in Hawaii, Alaska, and Puerto Rico. A little more than one-half of participating providers practiced within ten miles of either a VA or DoD facility. Figure 5 displays a map of respondents' practice locations, military treatment facility locations, and VA hospital or clinic locations. The map also includes a state-by-state indication of the veteran population as a proportion of the overall population.

Provider Activity

Across all provider types, respondents reported working an average of 48 hours per week ($SD=22.87$). They indicated spending the largest percentage of their time in direct patient care doing either medication management or psychotherapy and assessment (Table 5). Participating social workers, psychologists, and licensed counselors reported spending about half their time on psychotherapy and assessment. Participating psychiatrists reported spending a majority of their time

(59 percent) on medication management and only about 30 percent of their time on psychotherapy and assessment. Amount of participants' time spent on professional and administrative activities—such as committees, Continuing Medical Education, research, writing, training, and forensic activities—varied by provider type. For example, psychiatrists reported that they spend about 8 percent of their time on professional and administrative activities, whereas psychologists reported spending about 31 percent of their time on those activities.

Therapeutic Orientation

The primary therapeutic orientation reported by respondents also varied by provider type (Table 6). The majority of social worker and licensed counselor respondents reported that their primary therapeutic orientation was cognitive and/or behavioral. A large proportion of psychologists also identified cognitive and/or behavioral as their primary therapeutic orientation (41 percent), and others identified with integrative or eclectic approaches (30 percent). Psychiatrists generally identified biological/psychopharmacologic as their primary orientation.

Certification, Training, and Supervision in Therapeutic Techniques

Respondents indicated being certified or trained in an array of EBPs for PTSD and MDD and have been supervised by others

Figure 4: Percentage of Total Professional Hours Reported, by Clinical Setting

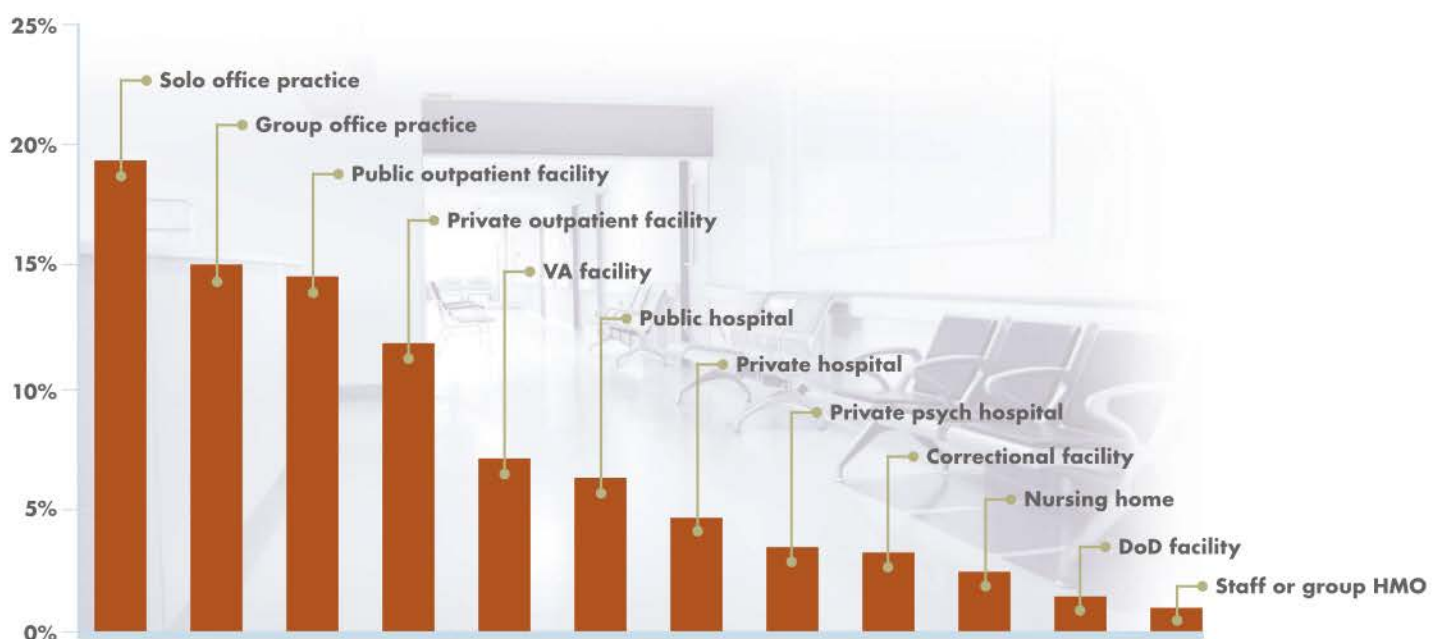


Table 4: Percentage of Patients Seen, by Respondents by Setting

	All (n=522)	Psychiatrists (n=128)	Psychologists (n=127)	Social Workers (n=132)	Licensed Counselors (n=135)
Outpatient setting	77.4	84.2	81.9	69.4	74.4
Inpatient setting	17.0	14.3	9.8	24.0	24.0
Other settings (school, prison, etc.)	5.0	1.5	8.3	6.6	5.6

in these methods. As Table 7 shows, CBT was the most common therapeutic technique respondents reported being trained to deliver, followed by IPT and CPT. Relatively fewer respondents had training and supervision in PE, EMDR, and SIT.

Assessment Behaviors

To understand the usual practice behaviors of participating providers, we asked them how often they implement a series of practices related to screening and assessment. While these screening behaviors are not necessarily linked specifically to quality or cultural competency, they do inform whether providers routinely adopt recommended approaches in their clinical settings. Figure 6 shows that the majority of respondents report often or always screening for a history of trauma, suicide risk, physical health problems, sleep issues, and pain. Only one-half reported screening for military affiliation and less than one-half report assessing stressors associated with military life. Less than one-half of the respondents reported often or always using validated screening tools to assess for such conditions as depression, PTSD, or alcohol and drug use.

MILITARY CULTURAL COMPETENCY

In this section, we report our findings on the military cultural competency of survey respondents. Cultural competency includes their knowledge and comfort related to military culture, self-reported proficiency working with veteran and military-affiliated patients, and prior training in military culture. We also report how individual and practice characteristics are associated with these aspects of military cultural competency. Understanding which factors are related to being more “veteran friendly” can help direct military cultural competency training to the set of providers most in need. We hypothesized that military cultural competency would be low among those providers who do not already treat veteran or military-affiliated patients.

Respondents reported being either “very familiar” or “extremely familiar” on an average of 1.84 ($SD=2.7$) of the eight military knowledge items presented and reported being “mostly comfortable” or “extremely comfortable” with an average of 1.62 ($SD=1.3$) of the three comfort items. A breakdown of knowledge items can be seen in Table 8, and indicates a wide range of self-reported knowledge on different aspects of military culture, with only 15 percent reporting being very or extremely familiar with military deployment and slang terms, but 38 percent saying they were very or extremely familiar with the way behaviors learned at war can be maladaptive at home. In terms of self-reported proficiency working with veteran or military-affiliated patients, respondents reported “agree” or “strongly agree” on an average of 4.52 ($SD=3.2$) of the ten proficiency items presented. A breakdown of self-reporting proficiency can be seen in Table 9, again with some differences across the items. Of the respondents, 18 percent agreed or strongly agreed that diagnosing and treating military personnel and veterans with mental health problems is no different than diagnosing and treating civilians with mental health problems, whereas 75 percent reported they usually actively strive to understand each military and veteran client’s values and beliefs. Thirty-four percent reported receiving prior training in military culture. When these items were compiled into the overall military cultural competency score, total scores averaged 8.32 ($SD=6.4$) out of a possible 22 points. Overall, 19 percent were categorized as having “high military cultural competency” (with a total score of 15 or greater).

Although 70 percent of those working in a military or VA setting had high military cultural competency, only 24 percent of those participating in the TRICARE network and 8 percent of those without military or TRICARE affiliation met this threshold ($p<0.001$; see Table 7). Nearly one-quarter (23 percent) of those practicing within ten miles of a VA or military treatment facility met the threshold for high military cultural competency, whereas only 15 percent of those practicing more distantly from these facilities met the thresh-

Figure 5: Map of Survey Respondents' Practice Locations, Military Treatment Facility Locations, and VA Hospitals or Clinics

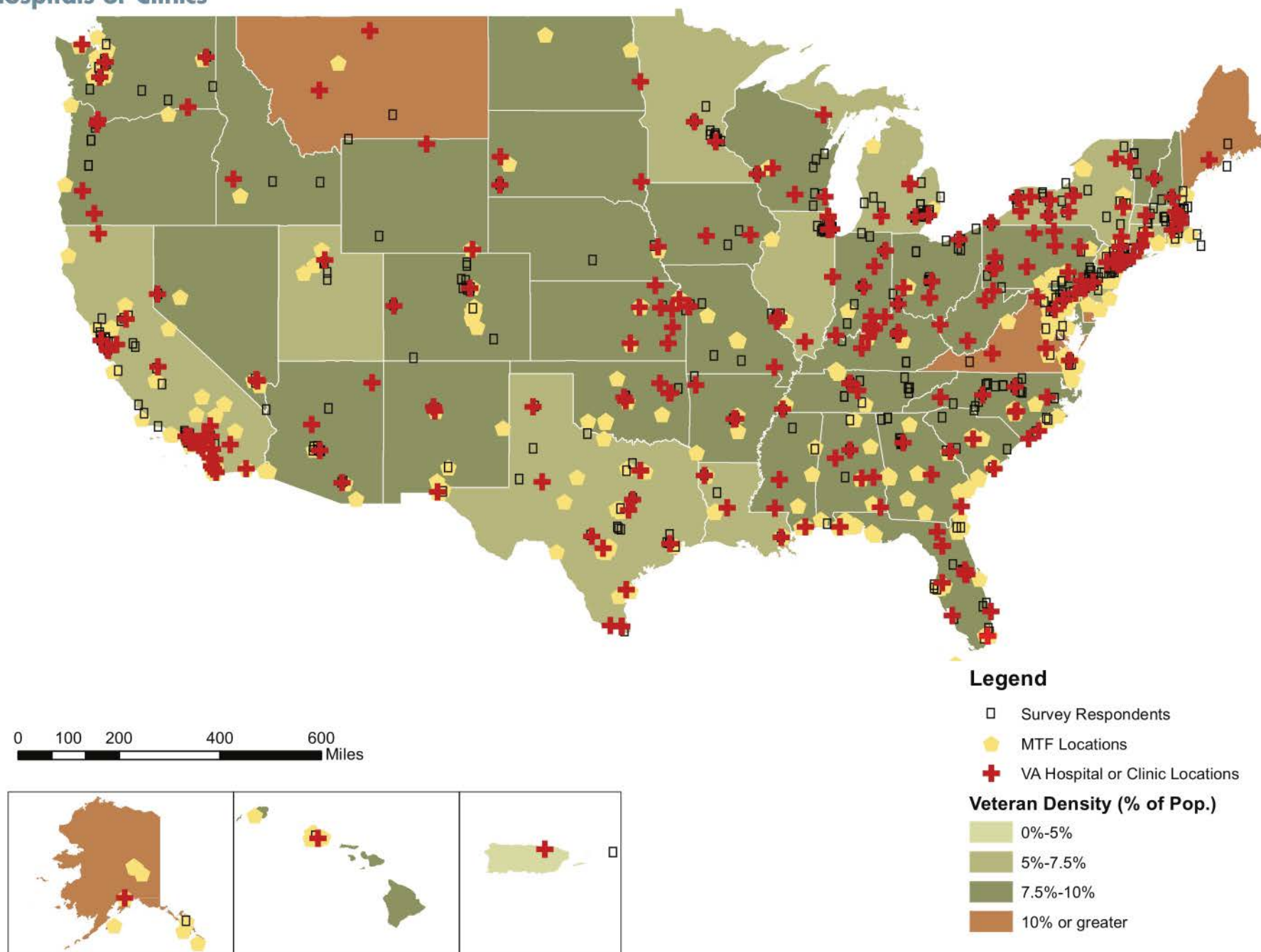


Table 5: Time Spent in Typical Week, by Activity (percentage)

	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
Psychotherapy or assessment	49.7	29.7	54.6	58.6	54.9
Medication management	21.7	58.5	2.8	4.1	15.8
Professional/administrative activities	20.8	7.6	31.4	23.0	20.1
Receiving supervision/consultation	7.3	4.2	5.9	9.5	9.0
Supervising others	6.6	3.7	8.8	8.7	5.1

Table 6: Provider Primary Therapeutic Orientation (percentage)

	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
Cognitive and/or behavioral	41.2	7.8	44.1	58.3	53.3
Biological/psychopharmacologic	21.8	71.8	0.8	1.5	14.1
Integrative or eclectic	17.8	12.5	29.9	16.7	12.6
Psychodynamic/relational	10.2	5.5	11.8	9.8	13.3
Interpersonal	4.8	0.0	6.3	10.6	2.2
Acceptance and commitment	1.1	0.0	1.6	0.7	2.2
Other	3.1	2.3	5.5	2.3	2.2

Table 7: Provider-Reported Psychotherapy Training and Supervision (percentage)

	All		Psychiatrists		Psychologists		Social Workers		Licensed Counselors	
	Trained	Supervised	Trained	Supervised	Trained	Supervised	Trained	Supervised	Trained	Supervised
CBT	69.4	68.6	57.0	63.3	71.6	68.5	67.4	61.4	80.7	80.7
IPT	37.0	37.4	40.6	50.0	37.0	35.4	25.8	21.2	45.2	42.9
CPT	33.0	27.6	18.0	17.2	35.4	23.6	28.8	25.0	50.4	43.7
EMDR	18.6	17.2	12.0	14.1	20.5	15.8	13.6	12.1	28.2	26.7
PE	18.0	16.9	14.0	15.6	24.4	25.2	11.4	5.3	22.9	21.5
SIT	13.6	10.9	6.3	6.3	15.8	11.0	9.1	6.1	22.9	20.0

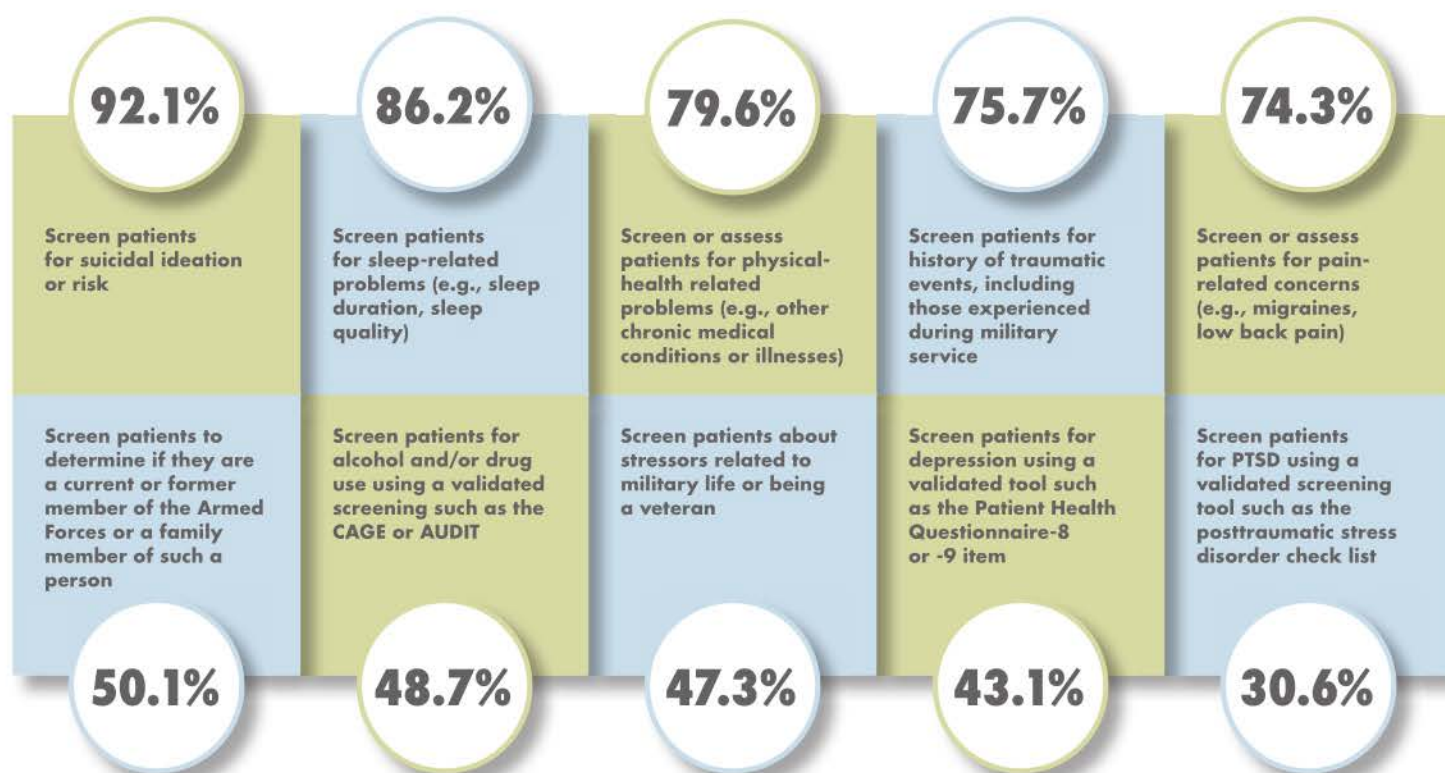
old ($p < 0.05$). Neither provider type nor years in practice were related to overall military cultural competency.

Consistent with the bivariate analyses (shown in Table 10), a logistic regression model confirmed that, relative to those working outside military or VA settings who are part of the TRICARE network, those working in military or VA settings are more likely to meet the threshold for high cultural competency, and those working outside such settings who are not part of TRICARE are less likely to meet the threshold. The remaining independent variables failed to reach significance. A linear regression predicting the continuous variable for military cultural competency showed similar results.³¹

USE OF EVIDENCE-BASED PRACTICES FOR PTSD AND MDD

In this section, we explore respondents' reported capability of delivering evidence-based care for PTSD and MDD. We report on whether participating providers were trained and inclined to implement guideline-concordant care for PTSD and MDD, and whether these providers reported using such care in their usual practice. The success of efforts to outsource mental health care for service members and veterans to civilian providers will depend, in part, on whether providers in the community are able and willing to deliver the high-quality care outlined in the VA/DoD CPGs for MDD and PTSD.³² Based on previous reviews of provider practices,³³ we expected that a substantial proportion of civilian providers would *not* be prepared to deliver high-quality mental health care.

Figure 6: Percentage of Providers Who Endorse Performing Each Assessment Behavior



We explored the relationships between training in and use of evidence-based care and psychotherapist type (social worker, licensed professional counselor, or clinical psychologist), military affiliation (employed in a military setting, TRICARE affiliated, or non-TRICARE affiliated), number of years since graduate training, and attitudes toward CPGs. Understanding the practice and provider characteristics associated with provision of high-quality mental health care may allow policymakers to better direct care for service members seeking services outside the military and veteran health systems.

The types of services specified as “evidence-based” differ substantially between mental health specialists (hereafter referred to as “psychotherapists”) and psychiatrists. Although psychiatrists are licensed to provide both medication management and “talk” therapies for mental health conditions, most deliver more medication management than psychotherapy (see also Table 3). Psychotherapists are not licensed to provide medications and are more likely than psychiatrists to deliver “talk” therapies, including EBP’s such as CBT or PE. This divergence in practice motivates our analytic structure. Below, we report first on psychotherapists’ training in and delivery of EBP’s for PTSD and MDD. Second, we report findings on

psychiatrists’ delivery of evidence-based medication management for PTSD and MDD.

Evidence-Based Practices Among Psychotherapists

Training in Evidence-Based Psychotherapies for PTSD and MDD

Only one-third (35 percent) of psychotherapists reported that they had been trained and received supervision to deliver at least one EBP for PTSD and at least one for depression (see Figure 6). Licensed counselors (LPC/LMHCs) were most likely to report having training in EBP’s ($p < .001$). Nearly one-half (48 percent) reported being trained to deliver an EBP for PTSD and depression. One-third of clinical psychologists reported receiving training (34 percent), and only one-fourth of licensed clinical social workers (LCSW/MCSWs) indicated they were trained (23 percent). Neither attitudes toward CPGs nor years since clinical training were significantly associated with EBP training. A logistic regression model predicting EBP training confirmed the bivariate relationships described above.³⁴

Table 8: Providers Reported Knowledge of Military and Veteran Culture (percentage)

Reported Being Very Familiar or Extremely Familiar With	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
Military rank structure	21.6	25.0	25.2	15.9	20.7
Subculture of military branches	16.5	16.4	17.3	13.6	18.5
Differences and similarities between active and reserve components of the military	23.6	30.5	14.4	18.9	20.7
General and deployment-related military slang and terms	14.6	14.8	15.7	12.9	14.8
General and deployment-related stressors for service members and veterans	25.1	21.9	32.3	23.5	23.0
General and deployment-related stressors for military families	27.2	23.4	32.3	27.3	25.9
Programs and services available to support healthy adjustment for military-affiliated clients	17.8	13.3	19.7	19.7	18.5
How behaviors learned in war can be maladaptive at home	37.5	29.7	48.0	37.9	34.8

Table 9: Self-Reported Proficiency (percentage)

Reported Agree or Strongly Agree	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
I can list methods or ways of collecting a military history and related mental health information (e.g., military and veteran benefits, options or eligibility for care)	40.4	39.1	43.3	42.4	37.0
I can explain how the perceptions of mental health beliefs are influenced by military and veteran culture	54.6	46.9	61.4	56.1	54.1
I usually actively strive to understand each military and veteran client's values and beliefs	74.5	75.8	77.2	77.3	68.1
I can teach and guide colleagues on the important features of military culture	25.1	22.7	26.0	25.0	26.7
I can teach and guide colleagues on planning mental health care for military and veteran clients	28.7	26.6	30.7	27.3	30.4
I can teach and guide colleagues on effective communication skills with military and veteran clients	39.5	31.3	44.1	40.2	42.2
Collecting information on a military or veteran client's mental health is easy for me	47.3	46.9	50.4	45.5	46.7
When implementing care, I can fulfill the mental health needs of military and veteran clients	54.2	56.3	57.5	48.5	54.8
I have the skills to communicate effectively with military and veteran clients	69.3	74.2	71.7	65.2	66.7
Diagnosing and treating military personnel and veterans with mental health problems is no different than diagnosing and treating civilians with mental health problems	18.4	21.9	16.5	12.1	23.0

Table 10: Relationship Between Cultural Competency and Provider Characteristics

Provider	Military Culturally Competent ≥ 15 (%)
All respondents	19.2
Provider type	
LPC or LMHC	17.8
LCSW or MCSW	18.2
Clinical Psychologist	21.3
Psychiatrist	19.5
	$\chi^2=0.621$, $p=\text{not significant (ns)}$
Affiliation	
Works in military or VA setting	70.5
TRICARE affiliated	23.7
Not TRICARE affiliated	7.7
	$\chi^2=133.38$, $p<.001$
Years since graduate training	
Ten years or less	20.7
More than ten years	18.4
	$\chi^2=0.389$, $p=\text{ns}$
Geographic proximity	
Within ten miles	14.7
More than ten miles	22.8
	$\chi^2=5.555$, $p<.05$

Delivery of Evidence-Based Psychotherapy to at Least Three-Quarters of Patients in the Most Recent Typical Work Week

One-third of psychotherapists (33 percent) self-reported that, in the most recent typical work week, they treated a substantial majority of their patients (≥ 75 percent) with an EBP (see Figure 6). Providers who had been trained to deliver at least one evidence-based PTSD and MDD psychotherapy (41 percent) were more likely than those without training (29 percent) to report delivering EBPs to most of their patients in the most recent typical week ($p<.05$). Providers with positive attitudes toward CPGs (45 percent) were also more likely than those with negative opinions about CPGs (31 percent) to report delivering EBPs to their patients. Among providers who self-reported delivering EBPs to most of their patients in the most recent typical week, fewer years had elapsed since their graduate training relative to providers who did not deliver EBPs to the majority of their patients (13.9 years and 16.7 years, respectively). A logistic regression model predicting self-reported delivery of EBP confirmed the bivariate relationships.³⁵

Consistent Use of Evidence-Based Psychotherapy Techniques in Session

About 30 percent of psychotherapists reported that they “often” or “always” used the psychotherapy techniques associated with at least one EBP for PTSD and MDD (see Table 11). Provider type was not related significantly to use of EBP techniques. Perhaps not surprisingly, positive attitudes toward CPGs and training in EBPs for PTSD and MDD significantly predicted frequent use of EBP techniques. Neither affiliation nor years since graduate training were significant predictors of EBP techniques. A logistic regression, conducted to estimate the independent contributions of the predictor variables, confirmed the bivariate relationships described above.³⁶

Evidence-Based Practices Among Psychiatrists

When asked to report the most common first-line medications that they would prescribe to a patient with PTSD or MDD, 89 percent of psychiatrists specified a medication that the VA/

Table 11: Relationship Between Provider Characteristics, and Training and Delivery of EBPs for PTSD and MDD

	Trained in 1+ EBPs for PTSD and MDD (%)	Reported Treating ≥75% of Patients with an EBP in the Last Typical Work Week (%)	Reported Often/Always Using EBP Techniques for PTSD and MDD (%)
All Respondents	35.0	33.0	29.4
Provider Type			
LPC or LMHC	48.2	36.3	32.6
LCSW or MCSW	22.7	31.1	22.0
Clinical Psychologist	33.9	31.5	33.9
	$\chi^2(2)=19.06, p<.001$	$\chi^2(2)=1.02, p=ns$	$\chi^2(2)=5.39, p=ns$
Affiliation			
Works in a VA or military setting	48.1	26.9	40.4
TRICARE affiliated	37.4	40.7	34.1
Not TRICARE affiliated	31.5	31.5	25.5
	$\chi^2(2)=5.50, p=ns$	$\chi^2(2)=3.56, p=ns$	$\chi^2(2)=5.81, p=ns$
Supportive of CPGs			
Below threshold	34.1	30.8	25.8
Above threshold	40.0	45.0	50.0
	$\chi^2(1)=0.77, p=ns$	$\chi^2(1)=4.61, p<.05$	$\chi^2(1)=14.40, p<.001$
Years since graduate training	$t(392)=0.64, p=ns$	$t(392)=2.36, p<.05$	$t(392)=1.59, p=ns$
Trained in 1+ EBP			
No	—	28.9	22.7
Yes	—	40.6	42.0
	—	$\chi^2(1)=5.53, p<.05$	$\chi^2(1)=16.20, p<.0001$

Providers who meet one threshold, such as culturally sensitive or competent, may not meet the other (trained in or report using evidence-based care).

DoD CPGs include as appropriate, evidence-based psychopharmacological treatments for these conditions. Psychiatrists' practice affiliation was not significantly related to their likelihood of prescribing an evidence-based medication ($\chi^2(2)=1.20$, $p=ns$). Evidence-based prescribing was also unrelated to attitudes toward CPGs ($\chi^2(2) = 2.09$, $p=ns$). However, years since graduate training were related to self-reported practices. Psychiatrists who adhered to practice guidelines for medication management of PTSD and MDD had been practicing for about five fewer years ($M=25.6$, $SD=7.93$) than those who reported not providing guideline-concordant care ($M=31.0$, $SD=9.02$; $t(126)=2.37$, $p<.05$).

Given that very few psychiatrists indicated that they would use a nonevidence-based medication management strategy ($n=14$), there was insufficient power to conduct a logistic regression predicting psychiatrist prescribing patterns with multiple independent variables.

OVERALL PROVIDER READINESS FOR VETERAN-FRIENDLY, QUALITY CARE

In this section, we explore the extent to which providers are "ready" to deliver culturally competent, high-quality care to veterans and their families. As we outlined in earlier sections, cultural competency can facilitate the development of therapeutic rapport and improve treatment receptivity, and the definition of *high-quality care* includes the use of treatments demonstrated to be effective (i.e., evidence-based). Thus, our concept of provider readiness in this study combines the domains of cultural competency and capacity to deliver high-quality care. We are particularly interested in understanding not only the

proportion of providers that meet our definition of readiness, but also in examining the factors that may be associated with such readiness. As we outlined in the previous sections, different factors have been shown to be associated with cultural competency and the use of evidence-based approaches. And, providers who meet one threshold, such as culturally sensitive or competent, may not meet the other (trained in or report using evidence-based care).

We operationalized our concept of readiness by building upon and combining the two outcomes described in the prior sections. We include providers we defined to be culturally competent (having scored 15 or greater out of a total of 22 possible on our cultural competency scale), who indicated they had been trained in an evidenced-based therapy for PTSD and MDD, and who self-reported using evidence-based treatments for PTSD and MDD. For each variable, the criteria for inclusion differed across MD and non-MD provider types due to the low numbers of psychiatrists who deliver nonmedication-based approaches. As we outlined in earlier sections, the focus for psychotherapists (non-MD providers) was on use of specific psychotherapies demonstrated to be effective for PTSD and MDD. For psychiatrists, evidence-based treatment meant selecting appropriate medications for PTSD and MDD. The previous section provides more detail on how providers perform separately on these two outcomes.

As shown in Table 12, only 13 percent of respondents met our readiness criteria. We examined associations between providers' years in practice (years since training in two categories: less than ten years, or ten years or greater), practice affiliation, proximity to military or veteran treatment facilities (within ten miles versus more than ten miles away), region (primary practice setting is in a metropolitan statistical area—defined urban or rural region), and insurance status (greater than 50 percent of patient care is not compensated through insurance). As shown, and as was confirmed in a multivariate model, we find that only providers' practice affiliation is significantly associated with readiness: Providers who work primarily in a military or VA setting were significantly more likely to meet our criteria for being culturally competent and delivering evidenced-based care for PTSD or MDD than providers who do not work in a military or VA facility, but those who indicated they were a registered provider within the TRICARE provider network were more likely to meet criteria than those who were not registered with a TRICARE provider network.

Table 12: Relationship Between Provider Characteristics and Readiness

	Culturally Competent and Reported Being Trained in 1+ EBP and Reported Often/Always Using Evidence-Based Treatment for PTSD and/or MDD (%)
All respondents	13.4
Provider type	
LPC or LMHC	13.3
LCSW or MCSW	9.8
Clinical psychologist	12.6
Psychiatrist	18.0
	$\chi^2=3.806, p=ns$
Affiliation	
Works in military or VA setting	45.9
TRICARE affiliated	17.8
Not TRICARE affiliated	5.5
	$\chi^2=75.149, p<.001$
Supportive of CPGs	
Not CPG friendly	13.2
CPG friendly	14.7
	$\chi^2=0.119, p=ns$
Years since graduate training	
Ten years or less	16.0
More than ten years	12.2
	$\chi^2=1.418, p=ns$
Geographic proximity	
Within ten miles of DoD or VA facility	15.9
More than ten miles	10.3
	$\chi^2=3.436, p=ns$

NOTE: Value and statistical tests are not shown for the associations between readiness and having greater than 50 percent of uncompensated/self-pay care because the number of providers in some cells were fewer than ten, making such tests unreliable.

As veterans and their families seek care to address mental health concerns, they will be turning to providers working across multiple sectors.

IMPLICATIONS FOR THE FUTURE

As veterans and their families seek care to address mental health concerns, they will be turning to providers working across multiple sectors. This study aimed to assess the readiness of those mental health providers working in community settings. While multiple factors may facilitate or inhibit a provider's ability to deliver high-quality care—including the system-level incentives and treatment models employed within their settings—we focused on those related to the characteristics of the providers themselves. To do so, we examined the characteristics of a convenience-based sample of mental health professionals and assessed their knowledge, attitudes, and behaviors with respect to military and veteran culture, as well as evidence-based practices for mental health problems common in veteran populations.

We find that providers vary in whether they report being knowledgeable in and comfortable with treating military- and veteran-affiliated patients. We also observe variation in the extent to which participating providers were trained in and demonstrated use of evidence-based treatments for PTSD and MDD. We found that, across our outcomes of interest, the characteristics of the provider are related to the setting in which they work.

With respect to cultural competency, respondents endorsed a high degree of knowledge on less than one-quarter of knowledge items, a high degree of comfort on about two-thirds of comfort items, and a high degree of proficiency on fewer than one-half of self-reported proficiency items. Fewer than one-fifth of respondents exceeded the threshold for a high degree of cultural competency, and as expected, those respondents were more likely to be working in DoD or VA work settings or to have reported being in the TRICARE network than not.

The majority of psychotherapists (65 percent) reported that they had not received the training and supervision necessary to deliver at least one EBP for PTSD and MDD. In other words, a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans with these conditions.

Licensed counselors (LPC/LMHC) were more likely than other psychotherapists to report adequate training in EBPs. Further examination of differences across graduate training models may provide policy recommendations to improve training for the next generation of psychotherapists.

Training in EBPs, in turn, predicts implementation of these practices with the majority of patients. Increasing community-based psychotherapists' incentives to complete training in EBPs may improve patient access to these behavioral treatments for their conditions. At the same time, even among psychotherapists with training, only 41 percent reported delivering evidence-based care to most of their patients. Thus, training alone does not ensure delivery of high-quality care; other barriers to CPG adherence must be explored. Providers who delivered EBPs to most of their patients were comparatively recent graduates, having completed their training about three years after those who were not consistently implementing evidence-based care. This may reflect a trend among graduate programs toward an increasing emphasis on evidence-based strategies for care, or it may be that younger clinicians are more likely to pursue training and supervision in treatments that have been demonstrated through research to reduce clinical symptoms.

Among psychiatrists, the majority of respondents reported prescribing appropriate medication for MDD and PTSD. In general, most reported using specific psychotropic medications that are considered generally acceptable for these conditions. However, we were unable to assess the appropriateness of specific dosages and length of use.

When we combined responses for cultural competency and use of evidence-based approaches to examine the level of overall readiness to deliver culturally competent, evidence-based care, we found very few respondents (13 percent) met our threshold. Similar to our findings on cultural competency, providers who met this threshold were more likely to be affiliated with a DoD or VA facility than not, and more likely to be a part of the TRICARE network than not if working outside DoD or the VA. Although actual knowledge and practice behaviors were not assessed in this study, the data

gathered on respondents' perceptions of their own knowledge, attitudes, and behaviors offer important insights into how ready they are to work with veterans and service members, as well as their families.

These findings suggest that when service members, veterans, or family members seek care from providers not affiliated with DoD or the VA, they may encounter providers who are not as well prepared to deliver culturally sensitive care. However, the degree to which providers deliver evidence-based care for PTSD and MDD appears equivalent across settings, with those providers who have received training in evidence-based approaches more likely to deliver such care routinely to their patients.

Study Limitations

While this study provides important insight into the characteristics of community mental health professionals, several limitations should be noted. First, we relied upon a convenience sample. Thus, the results are not necessarily representative of all mental health professionals. While the topics of military and veteran mental health care, cultural competency, and evidence-based practice were not specifically identified in the recruitment email sent by GfK or in the introductory page of the survey, it is possible that providers more interested in these topics of military and veteran populations completed the survey. As with all surveys conducted among convenience samples, it is difficult to understand the potential bias introduced by those choosing to participate in such panels and surveys as compared to the full population of providers.

Further, while we compare providers across different types of characteristics, care should be taken in making inferences about differences across provider groups because we did not sample systematically. Future work should be designed to implement similar assessments in larger samples, ideally those that are designed to represent provider groups (defined within provider networks, professional categories, settings, etc.). Another limitation is that we rely on self-report methods to assess practice behaviors. As with all self-report surveys, there is the potential for socially desirable responses. We tried to minimize this bias by including anchor/reference periods or referring to specific types of patients (e.g., those with PTSD or MDD); however, the potential for selecting socially desirable responses may still remain.

In addition, we measured some aspects of potential care experiences for veterans and their families within this survey, such as self-reported knowledge about military culture and proficiency with various treatment approaches, but did not

include others, such as actual knowledge on how to apply specific techniques and practice behaviors for these populations. Thus, many important aspects of knowledge, attitudes, and behavior among community-based mental health providers remain to be explored. Further, other techniques—such as gathering patient-level data on symptom levels, functioning, and experiences with care (which could be implemented within rigorous performance monitoring approaches)—would help to inform the extent to which providers' techniques are actually helping patients to improve.

Recommendations and Next Steps

Despite the exploratory nature of this study, there are several implications for informing future efforts to improve the capacity of community-based providers to deliver culturally competent, high-quality care to veterans and their families.

Conduct Better Assessments of Civilian Provider Capacity

With continued emphasis on hiring more providers into the VA,³⁷ workforce development and evaluation efforts are critically needed to understand more about the size and characteristics of the mental health workforce in the United States, and

These findings suggest that when service members, veterans, or family members seek care from providers not affiliated with DoD or VA, they may encounter providers who are not as well prepared to deliver culturally sensitive care.

While provider cultural competency may be important for engaging the population and thereby increasing access to care, other specific efforts may be needed to increase providers' use of quality therapeutic approaches.

in particular, whether the civilian sector can meet expectations regarding timeliness and quality of care. Unfortunately, at this time, there are no recent representative data on any of the specific professions within the mental health workforce.

Until such population-based data can be generated, organizations that maintain registries or provider networks of mental health professionals should conduct assessments related to their own networks, with a special focus on examining access and quality of care among those providers. Even registries or networks established specifically for military and veteran populations would benefit from an assessment of which providers have availability and appropriate capacity to render timely, culturally appropriate, high-quality care to veterans and their families. For example, while being part of such registries or networks may indicate a provider's willingness to accept military-affiliated patients, providers often place limits on the number of patients they accept under those arrangements. In this study, about 30 percent of providers reported they were part of the TRICARE network; however, TRICARE represented the primary payment source for only a small proportion (2.5 percent) of the patients treated by our participating providers in a typical week.

A related issue has to do with efforts to hire and train more providers working within DoD and the VA over the past several years. These efforts have been hampered by the ability to ensure an adequate pipeline of mental health providers, both in terms of numbers and quality, particularly in remote or rural areas. Several have pointed to the concerns about a national shortage in mental health,³⁸ and efforts to draw more providers into DoD and the VA may further deplete the civilian workforce. Again, careful study of the existing workforce may help to identify strengths and gaps and provide more information about how and where to enhance the pipeline of new professionals entering the workforce.

Assess the Impact of Trainings in Cultural Competency on Provider Capacity

In the President's 2012 Executive Order (and reinforced in new Executive Actions announced in August 2014), he called upon DoD, the VA, and the Department of Health and Human Services to collaborate in an effort to educate community-based providers about the unique needs of service members, veterans, and their families. In response to the most recent Call to Action, DoD and the VA announced an intent to disseminate their cultural competency course to civilian mental health providers. While this new initiative may help increase community-based providers' awareness of the unique issues of veterans and their families, training by itself it will not necessarily increase cultural competency or expand access or quality of care for veterans. While training may be an important underpinning for developing awareness and skills, seeing and interacting with the patient population was a significant predictor of overall competency, with providers' affiliation with DoD and VA settings and TRICARE affiliation significantly related to high military cultural competency scores in our scale.

Further, while provider cultural competency may be important for engaging the population and thereby increasing access to care, other specific efforts may be needed to increase providers' use of quality therapeutic approaches. DoD and the VA have a long history of requiring training for their providers on evidence-based approaches, as well as promulgating CPGs for the care of patients with specific conditions (including PTSD and depression), but there are few such requirements in the civilian setting. Large-scale dissemination and training efforts can be resource-intensive and require significant investment of staff time and leadership to promote participation and adherence to guidelines. Different models have been employed and many engage champions, train-the-trainer, or supportive implementation models to help disseminate information

broadly and encourage uptake. Often, these efforts also involve the development and distribution of provider resource guides, pocket tools, and other decisionmaking aids to facilitate utilization of the skills and practice recommendations. Studies that have evaluated the impact of these efforts have demonstrated success,³⁹ yet few programs that implement trainings of this nature evaluate their efficacy and long-term effectiveness. Many training and dissemination programs may show early success but adherence and use of new skills may wane as the support and infrastructure subsides.

DoD utilizes the Center for Deployment Psychology to train military mental health professionals in the evidence-based modalities. Recently, the Center began collaborating with academic organizations to bring training to civilian providers as well. Their approach includes specific focus on cultural competency, as well as evidence-based therapies, organized across three training tiers reflecting different topics and levels of intensity. Other promising programs have also begun designing and implementing more rigorous curricula on both the topics of cultural competency and specific evidence-based modalities using models shown to facilitate provider practice change.⁴⁰ Understanding the extent to which participating in such training affects providers' capability to serve this population will require well-designed evaluations of the training programs themselves, as well as rigorous studies to explore how providers implement the material in practice settings in the short and long terms.

Expand Access to Effective Trainings in Evidence-Based Approaches for PTSD and MDD

This study clearly points to the need for additional training on evidence-based approaches among the civilian mental health workforce, particularly for practitioners who completed their

formal professional training some time ago. Recent graduates in certain professions appear to be getting training in these models more often; thus, expansion to all professional training programs as well as to more mature professionals is needed. Over the past several years, numerous organizations have sought to implement training programs for practicing providers in evidence-based approaches in mental health, with varying success based upon the particular model adopted.⁴¹ As we outlined earlier, the type of training programs in military cultural competency and evidence-based approaches for PTSD and MDD currently available varies greatly—from short online courses, to lengthier in-person opportunities. Participation in these varying continuing education opportunities may help to expand provider skills and ability to implement these models; however, providers may need some additional motivation for attaining such training and then applying their new skills in routine practice.

While some of these training opportunities are available at little or no cost (such as web downloads), others may impose specific costs related to access and participation (including travel expenses). Beyond these participation fees, the participation time itself may be a cost for providers, as the time spent in training may detract from their time providing compensated patient care (particularly for providers working in independent, fee-for-service settings). Thus, strategies for facilitating low-cost access may be needed to increase provider willingness to participate. While some courses offer continuing education credits, not all provider groups and states have specific requirements for these credits and it may not be enough motivation to facilitate providers becoming trained. It should be noted that while we recommend greater access to training in evidence-based approaches for PTSD and MDD, we acknowledge that not all training may be equivalent in terms of quality and effectiveness in providing the appro-

This study clearly points to the need for additional training on evidence-based approaches among the civilian mental health workforce, particularly for practitioners who completed their formal professional training some time ago.

Improving the mental health of service members, veterans, and their families will require that the providers who treat them adopt and routinely use appropriate and effective approaches for addressing their conditions.

priate instruction and supervision in specific, evidence-based approaches. As such, rigorous evaluations will be needed to assess the extent to which training is effective in improving providers' skills and changing their practice behaviors.

Facilitate Providers' Use of Evidence-Based Approaches

Improving the mental health of service members, veterans, and their families will require that the providers who treat them adopt and routinely use appropriate and effective approaches for addressing their conditions. We found that prior training is associated with the use of evidence-based approaches; however, adoption of such techniques was not universal among those who received such training. Thus, providers may need additional motivation to use appropriate techniques in their usual practices. Supportive implementation models of training have shown success in increasing clinical skill acquisition and spreading evidence-based treatments among community providers, but other barriers to regular use may remain.⁴²

System- or practice-level performance-monitoring approaches and quality improvement techniques have been shown to improve providers' use of specific evidence-based

approaches.⁴³ These monitoring and improvement strategies may be applied more often within closely managed settings that prioritize quality—therefore, providers working in independent office practices may not be part of any such oversight other than what is provided through reimbursement mechanisms (e.g., claims adjudication processes). As such, motivating providers in private, independent settings within the civilian sector may require that health payers begin to monitor the quality of care provided more closely and consider strategies for incentivizing use of evidence-based approaches, either through altering reimbursement rates or providing preferred referral authorizations (particularly for those providers who choose not to accept any health insurance).⁴⁴

Prior research has demonstrated that there is a business case for providing access to high-quality care for all veterans with PTSD and MDD.⁴⁵ Thus, strategies for facilitating providers' use of evidence-based approaches have the potential to reduce the overall costs of such care and the burden on society associated with undertreated mental health conditions. Based on our findings, it is reasonable to expect that increasing training in and incentivizing providers' use of such techniques will begin to facilitate the delivery of high-quality care to veterans and their families.

Notes

¹ On August 31, 2012, President Obama signed Executive Order 13625, "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families." Government Printing Office. (2012) Retrieved October 8, 2014, from <http://www.gpo.gov/fdsys/pkg/DCPD-201200675/pdf/DCPD-201200675.pdf>.

² Hoge, C. W., et al. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351, 13–22; Hoge, C. W., Auchterlonie, J. L., & Milliken, C. S. (2006). Mental health problems, use of mental health services, and attrition from military service after returning from deployment to Iraq or Afghanistan. *Journal of the American Medical Association*, 295, 1023–1032; Tanielian, T., & Jaycox, L. (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Santa Monica, CA: RAND Corporation, MG-720-CCF, <http://www.rand.org/pubs/monographs/MG720.html>; Vasterling, J. J., et al. (2006). Neuropsychological outcomes of Army personnel following deployment to the Iraq War. *Journal of the American Medical Association*, 296, 519–529; Seal, K. H., Bertenthal, D., Miner, C. R., Sen, S., & Marmar, C. (2007). Bringing the war back home: Mental health disorders among 103,788 U.S. veterans returning from Iraq and Afghanistan seen at Department of Veterans Affairs facilities. *Archives of Internal Medicine*, 167, 476–482; Hoge, C. W., Terhakopian, A., Castro, C. A., Messer, S. C., & Engel, C. C. (2007). Association of posttraumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq war veterans. *American Journal of Psychiatry*, 164, 150–153; Tanielian, T., Martin, L.T., & Epley, C. (2014). *Enhancing capacity to address mental health needs of veterans and their families: The Welcome Back Veterans Initiative*. Santa Monica, CA: RAND Corporation, RR-719-MTF, http://www.rand.org/pubs/research_reports/RR719.html; Weinick, R. M., et al. (2011). *Programs addressing psychological health and traumatic brain injury among U.S. military servicemembers and their families*. Santa Monica, CA: RAND Corporation, TR-950-OSD, http://www.rand.org/pubs/technical_reports/TR950.html

³ Carter, P. (2013). *Expanding the net: Building mental health care capacity for veterans*. Washington, DC: Center for a New American Security.

⁴ Kizer, K. W., & Jha, A. K. (2014, July 24). Restoring trust in VA health care. *New England Journal of Medicine*, 371(4), 295–297; Chokshi, D. A. (2014). Improving health care for veterans—a watershed moment for the VA. *New England Journal of Medicine*, 371(4), 297–299.

⁵ Veterans' Access to Care through Choice, Accountability and Transparency Act of 2014, Public Law No. 114-146 (2014).

⁶ Meyer, T. (May 2013). *Serving those who served: A wise giver's guide to assisting veterans and military families*. Washington, DC: Philanthropy Roundtable. Retrieved March 26, 2014, from http://www.philanthropyroundtable.org/file_uploads/Serving_Those_Who_Served.pdf; Farmer, C. M., et al. (2011). *A needs assessment of New York State veterans: Final report to the New York State Health Foundation*. Santa Monica, CA: RAND Corporation, TR-920-NYSHF. Retrieved October 2, 2014, from http://www.rand.org/pubs/technical_reports/TR920.html; Berglass, N. (2010). *America's duty: The imperative of a new approach to warrior and veteran care*. Washington, DC: Center for a New American Security.

⁷ Weeklong projects: Citizen Soldier Project web site. (2014). Retrieved August 22, 2014, from <http://www.citizensoldiersupport.org/>; Massachusetts General Hospital Psychiatry Academy. (2014). *From the war zone to the home front: Supporting the mental health of veterans and families*. Retrieved August 22, 2014, from http://mghcme.org/page/from_the_war_zone_to_the_home_front; Steptoe Group, L.L.C. (2014). Mission statement. Retrieved August 22, 2014, from <http://thesteptoe-group.com/>; Center for Deployment Psychology (2014). *Trainings for military and civilian providers*. Retrieved September 15, 2014, from <http://www.deploymentpsych.org/psychological-training>. Certificate- or degree-awarding programs: USC Social Work. (2014). *Military Social Work and Veteran Services*. Retrieved August 22, 2014, from <http://sowkweb.usc.edu/master-of-social-work/msw-degree/sub-concentrations/military-socialwork-veteran-services>

⁸ Give An Hour website. (2014). Retrieved October 2, 2014, from <http://www.giveanhour.org/>; Star Behavioral Health Providers website. (2014). Retrieved August 22, 2014, from <http://www.starproviders.org/>

⁹ The Center for Veterans and Their Families at Rush. (2014). *Road Home Program*. Retrieved August 22, 2014, from <http://roadhomeprogram.org/>; NYU Langone Medical Center. (2014). *For Veterans & Military Families*. Retrieved August 22, 2014, from <http://psych.med.nyu.edu/veterans>; Tanielian, T., Martin, L.T. & Epley, C. (2014). *Enhancing capacity to address mental health needs of veterans and their families: The Welcome Back Veterans Initiative*. Santa Monica, CA: RAND Corporation, RR-719-MTF. Retrieved October 14, 2014, from http://www.rand.org/pubs/research_reports/RR719.html

¹⁰ IOM. (2014). *Treatment for posttraumatic stress disorder in military and veteran populations: Final assessment*. Washington, DC: National Academies Press.

¹¹ Kilpatrick, D. G., Best, C. L., Smith, D. W., Kudler, H., & Cornelison-Grant, V. (2011). *Serving those who have served: Educational needs of health care providers working with military members, veterans, and their families*. Charleston, SC: Medical University of South Carolina Department of Psychiatry, National Crime Victims Research & Treatment Center; Hoge et al., 2004; Wilk, J. E., et al. (2013). Use of evidence-based treatment for posttraumatic disorder in Army behavioral healthcare. *Psychiatry* 76(4); Koblinsky, S. A., Leslie, L., & Cook, E. T. (2014). Treating behavioral health conditions of OEF/OIF veterans and their families: A state needs assessment of civilian providers. *Military Behavioral Health*, 2, 162–172; Borah, E. V., et al. (2013). Implementation outcomes of military provider training in cognitive processing therapy and prolonged exposure therapy for post-traumatic stress disorder. *Military Medicine*, 178(9) 939.

¹² IOM Committee on Quality of Health Care in America. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academies Press.

¹³ IOM Committee on Quality of Health Care in America, 2001.

¹⁴ Coll, J. E., Weiss, E. L., Draves, P., & Dyer, D. (2012). The impact of military cultural awareness, experience, attitudes, and education on clinician self-efficacy in the treatment of veterans. *Journal of International Continuing Social Work Education*, 15(1), 39–48; Ganz, D., & Sher, L. (2013). Educating medical professionals about suicide prevention among military veterans. *International Journal of Adolescent Medicine and Health* 25(3), 187–191; Forgey, M. A., & Young, S. L. (2014). Increasing military social work knowledge: An evaluation of learning outcomes. *Health & Social Work* 39(1), 7–15; Lunasco, T. K., Goodwin, E. A., Ozanian, A. J., & Loflin, E. M. (2010). One shot-one kill: A culturally sensitive program for the warrior culture. *Military Medicine*, 175(7), 509–513; Weiss, E., Coll, J. E., & Metal, M. (2011). The influence of military culture and veteran worldviews on mental health treatment: Practice implications for combat veteran help-seeking and wellness. *International Journal of Health, Wellness & Society* 1(2).

¹⁵ Modified from Kilpatrick et al., 2011.

¹⁶ Experience working in a military setting was assessed with a single item querying experience working in a military treatment facility or within the VA. Thus, the data cannot be used to estimate the proportion who have worked in a military treatment facility only or in a VA setting only. Modified from Kilpatrick et al., 2011, to include military settings.

¹⁷ Modified from Zarin, D. A., et al. (1998). Characterizing psychiatry with findings from the 1996 National Survey of Psychiatric Practice. *American Journal of Psychiatry*, 155, 397–404; Walter Reed Institute of Research. (2010, March). Army behavioral health practice and treatment study. *WRAIR*, 1613, Version 003; and Wilk et al., 2013.

¹⁸ We used publicly available data files on the location of military and VA treatment facilities to map proximity. DoD MTF and medical facilities: Military Health System and Defense Health Agency. (Undated). DMIS ID Tables. Retrieved April 2014 from <http://www.tricare.mil/tma/gri/dmis/downloads.aspx>. VA facility locations: VA. (Undated) *Facilities by State*, Retrieved April 2014 from <http://www2.va.gov/directory/guide/allstate.asp>

¹⁹ We determined urban versus rural by using Metropolitan Statistical Area status by five-digit ZIP code.

²⁰ Perg, S. J., & Watson, R. (2012). Construct validation of the Nurse Cultural Competence Scale: A hierarchy of abilities. *Journal of Clinical Nursing*, 21(11–12), 1678–1684.

²¹ VA & DoD. (2009). *VA/DoD clinical practice guideline for management of major depressive disorder, version 2.0-2008*. Retrieved September 10, 2013, from http://www.healthquality.va.gov/mdd/MDD_FULL_3c1.pdf; VA & DoD. (2010). *VA/DoD clinical practice guideline for management of post-traumatic stress disorder, version 2.0*.

²² American Psychiatric Association. (2004). *Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder*, Washington, DC: American Psychiatric Association; Bisson, J., & Andrew, M. (2007). *Psychological treatment of post-traumatic stress disorder (PTSD)*. Cochrane Database Of Systematic Reviews, 3, CD003388; VA & DoD, 2009, 2010; Glenberg, A. J., et al. (2010). *Practice guideline for the treatment of patients with major depressive disorder*, Arlington, VA: American Psychiatric Association; Jonas, D. E., et al. (2013). *Psychological and pharmacological treatments for adults with posttraumatic stress disorder (PTSD)*. Rockville, MD: Agency for Healthcare Research and Quality. Retrieved September 18, 2013, from <http://effectivehealthcare.ahrq.gov/ehc/products/347/1435/PTSD-adult-treatment-report-130403.pdf>

²³ Wilk et al., 2013.

²⁴ Hepner, K. A., Azocar, F., Greenwood, G. L., Miranda, J., & Burnam, M.A. (2010, February). Development of a clinical report measure to assess psychotherapy for depression in usual care settings. *Administration and Policy Mental Health*, 37, 221–229.

²⁵ VA & DoD, 2009, 2010; American Psychiatric Association. (2006). *American Psychiatric Association practice guidelines for the treatment of psychiatric disorders: Compendium 2006*. American Psychiatric Publishers.

²⁶ IOM. (2011). *Clinical practice guidelines we can trust*. Washington, DC: The National Academies Press.

²⁷ New York State Psychiatric Association. (1997). *Improving treatment for depression: Survey of participating psychiatrists*.

²⁸ *Mental Health United States 2010* reports that of the clinically trained mental health personnel in the United States, females composed 32 percent of psychiatrists, 64 percent of psychologists, 65 percent of counselors, and 82 percent of social workers. Substance Abuse Mental Health Administration. (2010). *Mental Health United States 2010*. Table 45. Retrieved October 7, 2014, from <http://www.samhsa.gov/data/sites/default/files/MHUS2010/MHUS2010/MHUS-2010.pdf>

²⁹ Pew Research Center. (October 5, 2011). *The military-civilian gap: War and sacrifice in the post-9/11 era*. Washington, DC. Retrieved August 13, 2014, from <http://www.pewsocialtrends.org/files/2011/10/veterans-report.pdf>

³⁰ VA. (1946, January 30). *Policy memorandum number 2: Policy in association of veterans' hospitals with medical schools*. Retrieved September 2, 2014, from <http://www.va.gov/oaa/Archive/PolicyMemo2.pdf>

³¹ A logistic regression model was used to predict high cultural competency. Compared to the constant-only model, the full logistic regression model improved discrimination between those with high cultural competency and those that did not meet the threshold (Wald $\chi^2(6)=73.58$, $p<.0001$). Consistent with the bivariate analyses above, the Wald criterion confirmed that, relative to those working outside military or VA settings who are part of the TRICARE network, those working in military or VA settings are more likely to meet the threshold for high cultural competency ($OR=9.62$, $p<.0001$), and those working outside those settings who are not part of TRICARE are less likely to meet the threshold ($OR=0.36$, $p<.01$). The remaining independent variables failed to reach significance. A linear regression predicting the continuous variable for military cultural competency showed similar results.

³² VA & DoD, 2009, 2010.

³³ Pincus, H. A., et al. (1999). Psychiatric patients and treatments in 1997: Findings from the American Psychiatric Practice Research Network. *Archives of General Psychiatry*, 56, 441–449; IOM Committee on Quality of Health Care in America, 2001; McHugh, R. K. & Barlow, D. H. (2010). The dissemination and implementation of evidence-based psychological treatments: A review of current efforts. *American Psychologist*, 65(2), 73.

³⁴ A logistic regression was conducted to estimate the independent contributions of provider type, military affiliation, attitudes toward CPGs, and years since graduate training to the prediction of having received training/supervision in EBP for PTSD and MDD. Compared to the constant-only model, the full model improved discrimination between trained and untrained psychotherapists (Wald $\chi^2(6)=27.00$, $p<.001$). Consistent with the bivariate analyses, the Wald criterion confirmed that relative to LPC/LMHCs, clinical psychologists ($OR=0.52$) and licensed social workers ($OR=0.28$) were less likely to report receiving adequate training in EBPs for PTSD and MDD ($p<0.05$). The remaining predictor variables failed to reach significance.

³⁵ A logistic regression, in which all variables were entered simultaneously, examined the independent contribution of provider type, affiliation, attitudes toward CPGs, years since graduate training, and training in EBPs to the prediction of whether the provider used EBPs with most of their PTSD and MDD patients. The full model improved discrimination relative to the intercept-only model (Wald $\chi^2(7)=28.5$, $p<.001$). Consistent with the bivariate analyses, positive attitudes toward CPGs increased the likelihood that the provider would deliver EBPs to their patients ($OR=1.08$, $p<.0001$). As the length of time since a provider's clinical education increased, the likelihood that they would deliver EBPs to their patients with PTSD and MDD declined ($OR=0.97$, $p<.01$). Finally, providers who were trained in at least one MDD and one PTSD EBP were 1.6 times more likely to deliver EBPs to the majority of their patients ($OR=1.62$, $p<.05$). Provider type and affiliation were not significantly related to self-reported delivery of EBPs in the model.

³⁶ A logistic regression was conducted to estimate the independent contributions of provider type, affiliation, attitudes toward CPGs, years since graduate training, and training in EBPs to a prediction of likelihood of "often" or "always" implementing EBP techniques. Compared to the constant-only model, the full model improved discrimination between therapists who consistently versus inconsistently implement evidence-based techniques (Wald $\chi^2(7)=35.10$, $p<.0001$). Providers with positive attitudes toward CPGs were more likely to consistently implement EBP techniques ($OR=1.08$, $p<.001$). Providers who had been trained to deliver EBP were twice as likely to do so relative to those without training ($OR=2.16$, $p<.01$). The remaining model variables failed to reach significance.

³⁷ The White House, *Fact sheet: President Obama announces new executive actions to fulfill our promises to service members, veterans, and their families*, August 26, 2014. Retrieved October 14, 2014, from <http://www.whitehouse.gov/the-press-office/2014/08/26/fact-sheet-president-obama-announces-new-executive-actions-fulfill-our-p>

³⁸ Hoge, M. A., et al. (2013). Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. *Health Affairs*, 32(11), 2005–2012

- ³⁹ Karlin, B. E., et al. (2010, December). Dissemination of evidence-based psychological treatment of posttraumatic disorder in the Veterans Health Administration. *Journal of Traumatic Stress*, 23(6), 663–673; Karlin B. E., et al. (2012, October). National dissemination of cognitive behavioral therapy for depression in the Department of Veterans Affairs health care system: Therapist and patient-level outcomes. *Journal of Consulting and Clinical Psychology*, 80(5), 707–718.
- ⁴⁰ Murphy, R. A., & Fairbank J. A. (2013). Implementation and dissemination of military informed and evidence-based interventions for community dwelling military families. *Clinical Child and Family Psychology Review*, 16(4), 248–364.
- ⁴¹ Sholomaskas, D. E., et al. (2005, February). We don't train in vain: A dissemination trial of three strategies of training clinicians in cognitive behavioral therapy. *Journal of Consulting and Clinical Psychology*, 73(1), 106–115; Brookman-Frazee, L. I., Drahota, A., & Stadnick, N. (2012, August). Training community mental health therapists to deliver a package of evidence-based practice strategies for school-age children with autism spectrum disorders: A pilot study. *Journal of Autism and Developmental Disorders*, 42(8), 1651–1661.
- ⁴² Murphy & Fairbank, 2013.
- ⁴³ IOM, 2014.
- ⁴⁴ Burnam, M. A., Meredith, L. S., Tanielian, T. L., Jaycox, L. H. (2009). Mental health care for Iraq and Afghanistan veterans. *Health Affairs*, 28(3), 771–782.
- ⁴⁵ Tanielian, T., & Jaycox, L. (2008). *Invisible wounds of war: Psychological and cognitive injuries, their consequences, and services to assist recovery*. Santa Monica, CA: RAND Corporation, MG-720-CCF. Retrieved October 14, 2014, from <http://www.rand.org/pubs/monographs/MG720.html>

About the Authors

Terri Tanielian is a senior research analyst with expertise in military and veteran health policy research. Her research interests include access to and quality of mental health care; military suicide; military sexual assault; and psychological and behavioral effects of combat, terrorism, and disasters. In addition to this study, she leads several other RAND projects, including a study examining community-based models for expanding mental health care for returning veterans and their families under the Welcome Back Veterans Initiative.

Coreen Farris is a behavioral scientist at the RAND Corporation. Her research focuses on violence, mental health, and decisionmaking. Farris's recent work includes research on military sexual trauma, evaluation of programs to support psychological health following a military deployment, and strategies to improve medical decisionmaking under time pressure.

Caroline Epley is a project associate at the RAND Corporation. She has a broad range of research interests, skills, and experience, and her work at RAND has focused on military health and veterans' programs and policy, performance management, and technology in public service delivery. Her current work includes performance monitoring and analysis of the Welcome Back Veterans Initiative and project management and research for RAND's 2014 Workplace and Gender Relations Survey.

Carrie M. Farmer is a policy researcher at the RAND Corporation. She is leading several studies to identify and evaluate programs and services addressing psychological health and traumatic brain injury among service members, veterans, and their families. She has expertise in assessing the quality of mental health care, including the development of quality metrics. Her current and previous work involves analyses of mental health care quality in a variety of populations, including adult Medicaid beneficiaries and veterans.

Eric Robinson is a research programmer and analyst at the RAND Corporation. His research focuses on data-driven analyses of military personnel and operations. He was a coauthor and lead data analyst for Hidden Heroes, RAND's nationwide survey and assessment of military caregivers, and has contributed to the RAND Deployment Life Study.

Charles C. Engel is a widely published psychiatrist, mental health services researcher, and senior health scientist at the RAND Corporation. Before retiring as an Army Colonel, Dr. Engel was Associate Chair for Research, Department of Psychiatry, Uniformed Services University of the Health Sciences in Bethesda, Maryland.

Michael William Robbins is an associate statistician with the RAND Corporation. He has a diverse background in applied and theoretical statistics with methodological interests in change-point analysis, missing-data analysis, survey design, causal inference, time series analysis, multivariate analysis, and stochastic processes. Robbins is also interested in the application of statistics to a variety of topical areas, including economics, environment, health care, and defense policy.

Lisa H. Jaycox is a senior behavioral scientist who focuses on trauma, interventions, and mental health services for both adults and children. Her research is especially focused on dissemination of evidence-based practices into community settings, and evaluation of existing practices that focus on depression and anxiety.

About This Report

Ensuring that military veterans and their families have access to high-quality mental health care is a national priority. Over the past several years, the Departments of Defense and Veterans Affairs have increased the number of mental health professionals working within their facilities and have rolled out training and quality improvement initiatives designed to promote the use of evidence-based treatments. Despite these important efforts, research continues to demonstrate that many veterans prefer to seek services outside the Department of Defense and/or the Department of Veterans Affairs. Thus, providers working in the civilian sector are an increasingly important part of the overall mental health workforce addressing veterans' mental health needs.

To better understand a key aspect of our nation's ability to provide veterans and their families with access to high-quality mental health care, RAND conducted a survey of civilian mental health providers to gather information about their knowledge, attitudes, and preferences for delivering services to veterans and their families. This report provides the results of that survey. The findings and recommendations from this study should be relevant to individuals, organizations, and policy officials concerned about the capacity of the civilian health care sector to deliver culturally competent, high-quality services to veterans and their families.

The authors wish to thank several individuals who helped make this study a success. First, we thank Shelly Espinosa, Tracy Malone, and Kathy Beasley for their guidance and support with this project. We thank the mental health professionals who took the time to participate in our survey, as well as Carolyn Chu and Michael Lawrence from GfK Custom Research, who facilitated the implementation of the survey.

We thank our quality assurance reviewers, Lisa Meredith and David Riggs, for their constructive reviews. Collectively, their comments and feedback greatly enhanced the report. We also thank our report production team of editors and designers, including Arwen Bicknell, Steve Oshiro, and Tanya Maiboroda.

This research was sponsored by the United Health Foundation in collaboration with the Military Officers Association of America and conducted within RAND Health. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health. This research was co-led by Terri Tanielian and Lisa H. Jaycox. Questions about the report may be directed to Terri_Tanielian@rand.org.

Limited Print and Electronic Distribution Rights

This document and trademark(s) contained herein are protected by law. This representation of RAND intellectual property is provided for non-commercial use only. Unauthorized posting of this publication online is prohibited. Permission is given to duplicate this document for personal use only, as long as it is unaltered and complete. Permission is required from RAND to reproduce, or reuse in another form, any of our research documents for commercial use. For information on reprint and linking permissions, please visit www.rand.org/pubs/permissions.html.

Ensuring that military veterans and their families have access to high-quality mental health care is a national priority. Over the past several years, the Departments of Defense and Veterans Affairs have increased the number of mental health professionals working within their facilities and have rolled out training and quality improvement initiatives designed to promote the use of evidence-based treatments. Despite these important efforts, research continues to demonstrate that many veterans prefer to seek services outside the Department of Defense and/or the Department of Veterans Affairs. Thus, providers working in the civilian sector are an increasingly important part of the overall workforce addressing veterans' mental health needs. To better understand a key aspect of our nation's ability to provide veterans and their families with access to high-quality mental health care, RAND conducted a survey of civilian mental health providers to gather information about their competency with military and veteran culture and their training and experience treating posttraumatic stress disorder and depression. This report provides the results of that survey. The findings and recommendations from this study should be relevant to individuals, organizations, and policy officials concerned about the capacity of the civilian health care sector to deliver culturally competent, high-quality services to veterans and their families.



The RAND Corporation is a research organization that develops solutions to public policy challenges to help make communities throughout the world safer and more secure, healthier and more prosperous. RAND is nonprofit, nonpartisan, and committed to the public interest.

RAND's publications do not necessarily reflect the opinions of its research clients and sponsors. RAND® is a registered trademark.

www.rand.org

© Copyright 2014 RAND Corporation

\$17.50

ISBN-10 0-8330-8768-1
ISBN-13 978-0-8330-8768-3



From: (b)(6) </o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Monday, March 20, 2017
Date: Fri Mar 17 2017 17:12:35 CDT
Attachments: image001
image002.png
Stand up -March 20.docx

All,

Attached is the Morning Report for Monday, March 20, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Monday, March 20, 2017

Hot Issues

*March 16 and 17: House floor action: The House passed the following three bills.

- By a vote of 240-175, H.R. 1181, the Veterans 2nd Amendment Protection Act would prevent the names of Veterans who have been deemed incompetent for VA benefits purposes from being provided to the database used for firearms purchases, unless they have been found by a judicial authority to be a danger to themselves or others. The Administration issued a statement in support of the bill;

- By a vote of 237-178, H.R. 1259, the VA Accountability First Act would establish expedited removal authority for VA employees generally. It also includes measures to recoup relocation expenses and performance awards, allowing direct hiring for VAMC and VISN directors, and reduce benefits for VA employees convicted of certain crime. The Administration issued a statement in support of the bill. Two significant amendments failed which would have narrowed or modified the removal provisions in the bill, and a number of minor or technical changes were adopted by voice vote;

- By a vote of 412-0, H.R. 1367, which has been put forward as an effort to help VA hire and retain VA employees. Among the provisions are measures that would establish a fellowship program to encourage interchange of employees from the private sector, require performance appraisals of political appointees, broaden the application of Veteran's preference in employment, allow speedier hiring of former VA employees, require a central vacancy database, and strengthen training for HR professionals. The bill was modified in a number of respects to reduce the estimated cost of some provisions. A number of other minor or technical amendments were approved by voice vote.

Emerging

- None

Congressional Letters and Meeting Requests Received

- None

Friday, March 17, 2017 Events

- March 17, 2017. Mr. Michael Valentino, Chief Consultant, Pharmacy Benefits Management,

briefed Mr. James Cari, Manager, Legislative Policy and Strategy Development for the U.S. Postal Service, and discussed the loss of medications that occur during the shipping process. During the February 27, 2017, Hearing before HVAC-O&I, Dr. Clancy testified that 91.4 percent of reported drug losses occur in the mail (USPS and UPS).

10:00 A.M.; Teleconference

POC: (b)(6)

Summary: Mr. Valentino and others from Pharmacy Benefits Management (PBM) and the Consolidated Mail-Order Pharmacy Team were on line for VA. Mr. Cari was joined by U.S. Postal Service Investigators and a representative from USPS Office of Government Relations. After the February 27 HVAC-O&I hearing on Drug Diversions, the Committee asked USPS for follow up concerning VA's testimony that 94.1 percent of reported controlled substance losses occur during shipping. USPS requested the call with VA subject matter experts to get more information in order to better understand VA's data. Mr. Valentino explained the context of the hearing and what the data represented. USPS asked for an additional breakdown to include the number/percentage of controlled substances shipped by USPS vs UPS, the number/percentage shipped vs disbursed from a VA pharmacy and the actual amount of losses vs reported losses given that a delayed delivery may initially be reported as a loss as well as the number/percentage of actual losses attributable to USPS. PBM agreed to parse VA data to provide the requested breakouts.

· March 17, 2017. Sean Clark, National Coordinator, Veterans Justice Outreach Program, briefed Representative Coffman's on the Veterans Justice Outreach (VJO) program.

2:00 P.M.; Teleconference

POC: (b)(6)

Summary: Mr. Clark explained VJO Coordinators identify justice-involved Veterans and contact them through outreach, in order to facilitate access to VA services at the earliest possible point by building and maintaining partnerships between VA and key elements of the criminal justice system. The staff expressed concern that the program doesn't have the resources it needs to be fully successful. Mr. Clark conceded that there are resource problems. In closing, the staff said Rep. Coffman is interested in introducing legislation along with Senator Flake to allocate additional resources to the Veterans Justice Outreach Program.

· March 17, 2017. (Continued - March 9, 2017) Rob Thomas, OI&T, Acting Assistant Secretary, briefed SVAC minority staff on "VA's Major IT Projects."

2:00 P.M.; VACO, Room 703

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

· March 17, 2017. Willie Clark, Deputy Under Secretary for Field Operations, VBA and Mike Frueh, Chief of Staff, VBA, briefed SVAC minority staff regarding mandatory overtime.

2:00 P.M.; Teleconference

POC: (b)(6)

Summary: VBA staff provided a friendly update to SVAC minority staff regarding VBA's mandatory overtime effort beginning March 7. SVAC minority seemed to appreciate the information and expressed interest in VBA's assessment of the situation when the current 30-day effort ends in early April.

· March 17, 2017. (Postponed - March 14, 2017). Dr. Neil Evans, Co-Director, Connected Health, VHA briefed the Senate Veterans Affairs Committee on how VA provides mental healthcare to those in rural areas of the country – either through mobile providers or through telemedicine.

3:30 P.M.; VACO 511

POC: (b)(6)

Summary: Dr. Evans explained that Tele-Mental Health of information and telecommunication technologies to deliver mental health services when the provider and the Veteran are separated by geographical distance. The SVAC staff were interested to know about VA's plan for the Tele-Mental Health Hub in South Dakota and if VA had capacity to help treat National Guard soldiers that are in rural areas but not within their deployment window for coverage under Tricare. Dr. Evans responded that the Sioux Falls Telemental Health Hub plans to expand Tele-Mental Health services through implementation of Behavioral Health Interdisciplinary Program (BHIP) teams in the northern and southern CBOC tiers. The congressional staff were also interested in how Congress can help expand VA's Telehealth program. Dr. Galpin explained VA providers delivering Telehealth across State lines from a location not on Federal property, or to a patient not located on Federal property, have no clear protection from the enforcement of State laws that require local licensure. He also mentioned that VA is seeking legislation that allows VA providers to care for Veterans using Telehealth irrespective of the location of the provider or Veterans.

Look Ahead- Monday, March 20, 2017

· March 20, 2017. Dr. Yehia, Deputy Under Secretary for Health for Community Care, will brief SVAC Minority staff along with Sen. Tester's local staff on the Choice Program Scheduling Options for Montana.

10:30 A.M.; Teleconference

POC: (b)(6)

· March 20, 2017. Dr. Baligh Yehia, Assistant Deputy Under Secretary for Health - Community Care will brief members of Senator Steve Daines's staff regarding the Choice Program.

12:30 PM, Teleconference

POC: (b)(6)

- March 20, 2017. Margarita Devlin, Executive Director, Benefits Assistance Service, will brief staff from Congressman Robert Aderholt's (R-AL-04) office on education and training benefits available to service members upon departing the military.

1:30 P.M.; 235 Cannon

POC: (b)(6)

Government Accountability Office (GAO) Activity:

Entrance Conference

- March 20, 2017. In response to a request by the Chairs of the House Armed Services Committee and the House Veterans' Affairs Committee, GAO is beginning its work on Reverse Auctions (GAO Code 101428).

GAO's key questions:

- What are the trends in use of reverse auctions over the past 5 years?
- What steps have the agencies taken to improve the use of reverse auctions?
- To what extent did agencies achieve benefits through reverse auctions, such as enhanced competition and savings, with consideration of fees paid?

1:00 P.M.; VACO, Room 632

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

- March 21, 2017. (Tentative). The HVAC EO Subcommittee has informally notified VA it intends to hold a legislative hearing. The only bill on the agenda at this time concerns "official time" and other labor management and personnel matters. VA witnesses have not been established.

Time: TBD.; Room TBD

POC: (b)(6)

- March 22, 2017. Joint Hearing of the House and Senate Committee's on Veterans' Affairs to receive the Legislative Presentation of Multiple Veterans Service.

10:00 A.M.; G-50 Dirksen

POC: (b)(6)

- March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans' Affairs, Subcommittee on Health will conduct an oversight hearing on "Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers."

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

- March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

Time 1:30 pm.; Room: Cannon 334

POC: (b)(6)

- March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

Time 8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.
- H.R. 467 - The VA Scheduling Accountability Act.
- H.R. 907 - The Newborn Care Improvement Act.
- H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
- H.R. 1005 - To improve the provision of adult day health care services for Veterans.

- H.R. 1058 - The VA Provider Equity Act.
- H.R. 1162 - The No Hero Left Untreated Act.
- H.R. 1545- VA Prescription Data Accountability Act of 2017
- Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
- Draft Bill - To prohibit smoking in any VHA facility.

· April 5, 2017. (Tentative). The HVAC Disability and Memorial Affairs Subcommittee has informally notified VA it intends to hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

Time TBD; Room TBD

POC: (b)(6)

Tentative Agenda (Couple more bills may come)

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- Draft Bill Beneficial Travel for VBA (authorization fix) will send)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Brownley

Julia

CA

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

O'Rourke

Beto

TX

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bost

Mike

IL

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA

State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA

State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA

State Visit Request

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA

Delaware State Veterans Summit

Sen

McCaskill

Claire

MO

Call

3/21/2017

Arla Harrell Act

Sen

Gillibrand

Kirsten

NY

Call

3/22/2017

Blue Water Navy

Sen

Sanders

Bernie

VT

Meeting

3/23/2017

Privatization, Choice, Drug Costs

(Meeting in Office of Secretary)

Rep

Mast

Brian

FL

Meeting

4/3/2017

Meet & Greet

Sen

Murray

Patty

WA

Call/Meeting

3/8/2017

Caregivers

Rep

Sablan

Gregorio

NMI

Meeting

3/7/2017

Access to Care in the Northern Marianas Islands

Sen

Duckworth

Tammy

IL

Call

3/8/2017

TBD

HVAC Minority Member Retreat

Meeting

(Annapolis)

3/24/2017

SecVA's Way Forward for VA

Rep

McMorris Rogers

Cathy

WA

Meeting

3/24/2017

VA issues and Moving Forward in the 115th

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Sen

Klobuchar

Amy

MN

Call

3/16/2017

Burn Pit Legislation

Owner: (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)>
Filename: image001 <extracted>
Last Modified: Fri Mar 17 17:12:35 CDT 2017

This document contains proprietary information and should not be released, in whole or in part, to non -VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or competing Member offices that should not be shared with other congressional entities

Owner: (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: image002.png
Last Modified: Fri Mar 17 17:12:35 CDT 2017

Page 002 of 002
Printed Item 6 (Attachment 2 of 3)
This information should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or competing Member offices that should not be shared with other entities.
Page 370 of 974

Owner: (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn (b)(6)
Filename: Stand up -March 20.docx
Last Modified: Fri Mar 17 17:12:35 CDT 2017

FOR INTERNAL USE ONLY

Secretary's Morning Report
Prepared by the Office of Congressional & Legislative Affairs
Monday, March 20, 2017

This document contains proprietary information and should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or **competing** Member offices that should not be shared with other congressional entities

Hot Issues

March 16 and 17: House floor action: The House passed the following three bills.

By a vote of 240-175, **H.R. 1181, the Veterans 2nd Amendment Protection Act** would prevent the names of Veterans who have been deemed incompetent for VA benefits purposes from being provided to the database used for firearms purchases, unless they have been found by a judicial authority to be a danger to themselves or others. The Administration issued a statement in support of the bill;

By a vote of 237-178, **H.R. 1259, the VA Accountability First Act** would establish expedited removal authority for VA employees generally. It also includes measures to recoup relocation expenses and performance awards, allowing direct hiring for VAMC and VISN directors, and reduce benefits for VA employees convicted of certain crime. The Administration issued a statement in support of the bill. Two significant amendments failed which would have narrowed or modified the removal provisions in the bill, and a number of minor or technical changes were adopted by voice vote;

By a vote of 412-0, **H.R. 1367**, which has been put forward as an effort to help VA hire and retain VA employees. Among the provisions are measures that would establish a fellowship program to encourage interchange of employees from the private sector, require performance appraisals of political appointees, broaden the application of Veteran's preference in employment, allow speedier hiring of former VA employees, require a central vacancy database, and strengthen training for HR professionals. The bill was modified in a number of respects to reduce the estimated cost of some provisions. A number of other minor or technical amendments were approved by voice vote.

Emerging

None

Congressional Letters and Meeting Requests Received

None

Friday, March 17, 2017 Events

March 17, 2017. Mr. Michael Valentino, Chief Consultant, Pharmacy Benefits Management, briefed Mr. James Cari, Manager, Legislative Policy and Strategy Development for the U.S. Postal Service, and discussed the loss of medications that occur during the shipping process.

FOR INTERNAL USE ONLY

During the February 27, 2017, Hearing before HVAC-O&I, Dr. Clancy testified that 91.4 percent of reported drug losses occur in the mail (USPS and UPS).

10:00 A.M.; Teleconference

POC: (b)(6)

Summary: Mr. Valentino and others from Pharmacy Benefits Management (PBM) and the Consolidated Mail-Order Pharmacy Team were on line for VA. Mr. Cari was joined by U.S. Postal Service Investigators and a representative from USPS Office of Government Relations. After the February 27 HVAC-O&I hearing on Drug Diversions, the Committee asked USPS for follow up concerning VA's testimony that 94.1 percent of reported controlled substance losses occur during shipping. USPS requested the call with VA subject matter experts to get more information in order to better understand VA's data. Mr. Valentino explained the context of the hearing and what the data represented. USPS asked for an additional breakdown to include the number/percentage of controlled substances shipped by USPS vs UPS, the number/percentage shipped vs disbursed from a VA pharmacy and the actual amount of losses vs reported losses given that a delayed delivery may initially be reported as a loss as well as the number/percentage of actual losses attributable to USPS. PBM agreed to parse VA data to provide the requested breakouts.

March 17, 2017. Sean Clark, National Coordinator, Veterans Justice Outreach Program, briefed Representative Coffman's on the Veterans Justice Outreach (VJO) program.

2:00 P.M.; Teleconference

POC: (b)(6)

Summary: Mr. Clark explained VJO Coordinators identify justice-involved Veterans and contact them through outreach, in order to facilitate access to VA services at the earliest possible point by building and maintaining partnerships between VA and key elements of the criminal justice system. The staff expressed concern that the program doesn't have the resources it needs to be fully successful. Mr. Clark conceded that there are resource problems. In closing, the staff said Rep. Coffman is interested in introducing legislation along with Senator Flake to allocate additional resources to the Veterans Justice Outreach Program.

March 17, 2017. (Continued - March 9, 2017) Rob Thomas, OI&T, Acting Assistant Secretary, briefed SVAC minority staff on "VA's Major IT Projects."

2:00 P.M.; VACO, Room 703

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

March 17, 2017. Willie Clark, Deputy Under Secretary for Field Operations, VBA and Mike Frueh, Chief of Staff, VBA, briefed SVAC minority staff regarding mandatory overtime.

2:00 P.M.; Teleconference

POC: (b)(6)

Summary: VBA staff provided a friendly update to SVAC minority staff regarding VBA's mandatory overtime effort beginning March 7. SVAC minority seemed to appreciate the information and expressed interest in VBA's assessment of the situation when the current 30-day effort ends in early April.

FOR INTERNAL USE ONLY

March 17, 2017. (Postponed - March 14, 2017). Dr. Neil Evans, Co-Director, Connected Health, VHA briefed the Senate Veterans Affairs Committee on how VA provides mental healthcare to those in rural areas of the country – either through mobile providers or through telemedicine.

3:30 P.M.; VACO 511

POC: (b)(6)

Summary: Dr. Evans explained that Tele-Mental Health of information and telecommunication technologies to deliver mental health services when the provider and the Veteran are separated by geographical distance. The SVAC staff were interested to know about VA's plan for the Tele-Mental Health Hub in South Dakota and if VA had capacity to help treat National Guard soldiers that are in rural areas but not within their deployment window for coverage under Tricare. Dr. Evans responded that the Sioux Falls Tele-Mental Health Hub plans to expand Tele-Mental Health services through implementation of Behavioral Health Interdisciplinary Program (BHIP) teams in the northern and southern CBOC tiers. The congressional staff were also interested in how Congress can help expand VA's Telehealth program. Dr. Galpin explained VA providers delivering Telehealth across State lines from a location not on Federal property, or to a patient not located on Federal property, have no clear protection from the enforcement of State laws that require local licensure. He also mentioned that VA is seeking legislation that allows VA providers to care for Veterans using Telehealth irrespective of the location of the provider or Veterans.

Look Ahead- Monday, March 20, 2017

March 20, 2017. Dr. Yehia, Deputy Under Secretary for Health for Community Care, will brief SVAC Minority staff along with Sen. Tester's local staff on the Choice Program Scheduling Options for Montana.

10:30 A.M.; Teleconference

POC: (b)(6)

March 20, 2017. Dr. Baligh Yehia, Assistant Deputy Under Secretary for Health - Community Care will brief members of Senator Steve Daines's staff regarding the Choice Program.

12:30 PM, Teleconference

POC: (b)(6)

March 20, 2017. Margarita Devlin, Executive Director, Benefits Assistance Service, will brief staff from Congressman Robert Aderholt's (R-AL-04) office on education and training benefits available to service members upon departing the military.

1:30 P.M.; 235 Cannon

POC: (b)(6)

Government Accountability Office (GAO) Activity:

Entrance Conference

March 20, 2017. In response to a request by the Chairs of the House Armed Services Committee and the House Veterans' Affairs Committee, GAO is beginning its work on *Reverse Auctions* (GAO Code 101428).

FOR INTERNAL USE ONLY

GAO's key questions:

What are the trends in use of reverse auctions over the past 5 years?

What steps have the agencies taken to improve the use of reverse auctions?

To what extent did agencies achieve benefits through reverse auctions, such as enhanced competition and savings, with consideration of fees paid?

1:00 P.M.; VACO, Room 632

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

March 21, 2017. (Tentative). The HVAC EO Subcommittee has informally notified VA it intends to hold a legislative hearing. The only bill on the agenda at this time concerns "official time" and other labor management and personnel matters. VA witnesses have not been established.

Time: TBD.; Room TBD

POC: (b)(6)

March 22, 2017. Joint Hearing of the House and Senate Committee's on Veterans' Affairs to receive the Legislative Presentation of Multiple Veterans Service.

10:00 A.M.; G-50 Dirksen

POC: (b)(6)

March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans' Affairs, Subcommittee on Health will conduct an oversight hearing on "Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers."

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

Time 1:30 pm.; Room: Cannon 334

POC: (b)(6)

March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

Time 8:00 A.M.; 334 Cannon

POC: (b)(6)

H.R. 91 - The Building Supportive Networks for Women Veterans Act.

FOR INTERNAL USE ONLY

H.R. 95 - The Veterans' Access to Child Care Act.
H.R. 467 - The VA Scheduling Accountability Act.
H.R. 907 - The Newborn Care Improvement Act.
H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
H.R. 1005 - To improve the provision of adult day health care services for Veterans.
H.R. 1058 - The VA Provider Equity Act.
H.R. 1162 - The No Hero Left Untreated Act.
H.R. 1545- VA Prescription Data Accountability Act of 2017
Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
Draft Bill - To prohibit smoking in any VHA facility.

April 5, 2017. (Tentative). The HVAC Disability and Memorial Affairs Subcommittee has informally notified VA it intends to hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

Time TBD; Room TBD

POC: (b)(6)

Tentative Agenda (Couple more bills may come)

HR 1328 (Bost)-Auto COLA
 HR 1329 (Bost)-Annual COLA
 HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
 Draft Bill Beneficial Travel for VBA (authorization fix) will send)
 HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
 Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
 HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders

Sen/Rep	Last Name	First Name	State	Type of Engagement	Received	Date Scheduled	Topic
Rep	Brownley	Julia	CA	Meeting	3/15/2017		VA Priorities To Be Rescheduled from 3/15
Rep	O'Rourke	Beto	TX	Meeting	3/15/2017		VA Priorities To Be Rescheduled from 3/15
Rep	Bergman	Jack	MI	Meeting	3/15/2017		VA Priorities To Be Rescheduled from 3/15
Rep	Bost	Mike	IL	Meeting	3/15/2017		VA Priorities To Be Rescheduled from 3/15
Sen	Sullivan	Dan	AK	Travel	2/1/2017		SecVA State Visit Request
Sen	Tester	Jon	MT	Travel	2/1/2017		SecVA State Visit Request

FOR INTERNAL USE ONLY

Sen	Manchin	Joe	WV	Travel	2/1/2017		SecVA State Visit Request
Sen	Carper	Tom	DE	Travel		4/3/2017	SecVA Delaware State Veterans Summit
Sen	McCaskill	Claire	MO	Call		3/21/2017	Arla Harrell Act
Sen	Gillibrand	Kirsten	NY	Call		3/22/2017	Blue Water Navy
Sen	Sanders	Bernie	VT	Meeting		3/23/2017	Privatization, Choice, Drug Costs (Meeting in Office of Secretary)
Rep	Mast	Brian	FL	Meeting		4/3/2017	Meet & Greet
Sen	Murray	Patty	WA	Call/Meeting	3/8/2017		Caregivers
Rep	Sablan	Gregorio	NMI	Meeting	3/7/2017		Access to Care in the Northern Marianas Islands
Sen	Duckworth	Tammy	IL	Call	3/8/2017		TBD
	HVAC Minority Member Retreat			Meeting (Annapolis)		3/24/2017	SecVA's Way Forward for VA
Rep	McMorris Rogers	Cathy	WA	Meeting		3/24/2017	VA issues and Moving Forward in the 115 th
Rep	Arrington	Jodey	TX	Meeting	3/14/2017		VA Priorities – Proactive
Sen	Daines	Steve	MT	Travel	1/25/2017		Ft Harrison
Rep	Esty	Elizabeth	CT	Travel	3/15/2017		Newington & Farmington, CT
Rep	Kuster	Ann McClane	NH	Travel	3/15/2017		Nashua, NH Homelessness/Suicide
Sen	Klobuchar	Amy	MN	Call	3/16/2017		Burn Pit Legislation

From: (b)(6) </o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Friday, March 17, 2017
Date: Thu Mar 16 2017 16:36:51 CDT
Attachments: image001
image002.png
Stand up -March 17.docx

All,

Attached is the Morning Report for Friday, March 17, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Friday, March 17, 2017

Hot Issues

- None

Emerging

- None

Congressional Letters and Meeting Requests Received

- March 16, 2017. Ranking Member Senator Jon Tester (SVAC), and 17 other Senators expressed concern over sexual harassment reports regarding female service members and Veterans.
 - o Received March 16, 2017: VAIQ #7781860

Thursday March 16, 2017 Events

- March 15, 2017. Barbara Ward, Director, Center for Minority Veterans, briefed

Rep. Sanford Bishop (D-GA-02) on services the Center provides and the advisory committee's most recent recommendations from their 2016 annual report.

4:00 P.M.; 2407 Rayburn

POCs: (b)(6)

Summary: Barbara Ward, opened the dialogue providing background knowledge and statute history of the VA Center for Minority Veterans (CMV) and the Advisory Committee on Minority Veterans (ACMV), of which Rep. Bishop stated he was familiar with due to his years of Congressional Black Caucus-Veterans' Braintrust Committee engagement and commitment. In addition, Ms. Ward highlighted the recently published 2017 Minority Veterans Report, which reflects current and future Minority Veterans' demographics and utilization of VA benefits and services. Ms. Ward also covered the CMV strategic plan and current targeted outreach initiatives. She reviewed the role of the Advisory Committee on Minority Veterans and pointed out specific recommendations within the 2016 ACMV report. Rep. Bishop asked questions regarding the ACMV, especially screening and the selection process of committee members, and support from senior VA leadership. Ms. Ward provided assurance that VA senior leadership is critical to and supportive of the ACMV member selection process and that VA leadership value the recommendations submitted annually by the ACMV. In addition to leadership support of the ACMV, Ms. Ward indicated leadership support for the CMV's targeted outreach efforts. Rep. Bishop

asked for specific information regarding challenges identified as a result of the 2016 ACMV Report. In response, Ms. Ward and Mr. Newsome (Deputy Director, CMV) referred to the ACMV's recommendations with specific attention towards the VA gathering comprehensive demographic (race/ethnicity) data to enhance access to VA benefits and services, and support for the VA Office of Health Equity to identify and address health disparities. Lastly, Rep. Bishop encouraged ensuring that members within the HVAC and Tri-Caucus have access to the 2017 Minority Veterans Report and the 2016 Advisory

Committee on Minority Veterans Report.

· March 16, 2017. Subject Matter Experts from VBA's Pension and Fiduciary Services had a teleconference with SVAC Minority staff to discuss VA's FY17 legislative proposals on fiduciaries.

12:30 P.M.; Teleconference

POC: (b)(6)

Summary: SVAC Minority staff requested information to gather context on fiduciary misuse and the legislative proposals from the VA. Two of the proposals discussed were on the reissuance of VA benefit payments to all victims of misuse and the exemption to the right to the Financial Privacy Act by fiduciaries of VA beneficiaries. Minority staff indicated that the proposal to reissue VA benefit payments of fiduciary misuse was noncontroversial within the Committee. SVAC minority staff appreciated the call and predicted that these issues will likely be brought up in the near future but did not give a

specific timeframe.

· March 16, 2017. Dr. Ron Maurer, Acting Deputy Assistant Secretary for Congressional and Legislative Affairs, met with staff from Congressman Brian Mast's (R-FL) office to discuss the recent engagement at the West Palm Beach VAMC.

2:30P.M.; 2184 Rayburn House Office Building

POC: (b)(6)

Summary: Dr. Maurer and the Congressman's staff discussed the Congressman's visit to the West Palm Beach VAMC on Tuesday.

· March 16, 2017. Bridget McGregor, RN Manager, HCBS, Patient Care Services and Curtis Jordan, VISN 19 Network Contract Manager provided an overview of the current nursing home situation in Montana to the Senate Veterans Affairs Committee and Senator Tester's State Staff.

3:30 P.M.; 825A Hart

POC: (b)(6)

Summary: SVAC staff is concerned with potential access issues to nursing homes for Veterans in Montana and nationwide because local nursing home companies have reported they are not renewing their contracts because they are unsatisfied with the government's payment rates. The staff asked if VA was working with nursing homes via contracts or provider agreements. Mr. Jordan said that he found it problematic that VA did not use provider agreements. The Senate staff thanked him for his response

and stated that they would continue to urge VA to use provider agreements more often. Mr. Curtis also explained the Service Contract Act requires general contractors performing services on contracts to pay service employees in various classes no less than the wage rates and benefits found in the locality which some nursing homes cannot afford. The congressional staff also asked if there are enough contracts in place to meet the demand. Ms. McGregor explained that there are 115 Veterans in nursing homes in Montana across 36 contracts and that there is never a waitlist to gain access to nursing homes. In closing, the congressional staff said the meeting was very helpful and asked that VA provide them with a schedule of contract renewals and a description of what is being done at VA Central Office to track access and availability of nursing homes.

Look Ahead- Friday, March 17, 2017

· March 17, 2017. Mr. Michael Valentino, Chief Consultant, Pharmacy Benefits Management, will speak with Mr. James Cari, Manager, Legislative Policy and Strategy Development for the U.S. Postal Service, to discuss loss of medications that occur during the shipping process. During the February 27, 2017, Hearing before HVAC-O&I, Dr. Clancy testified that 91.4 percent of reported drug losses occur in the mail (USPS and UPS).

10:00 A.M.; Teleconference

POC: (b)(6)

· March 17, 2017. Sean Clark, National Coordinator, Veterans Justice Outreach Program, will brief Representative Coffman's on the Veterans Justice Outreach (VJO) program.

2:00 P.M.; Teleconference

POC: (b)(6)

· March 17, 2017. (Continued - March 9, 2017) Rob Thomas, OI&T, Acting Assistant Secretary, provided a briefing to SVAC minority staff on "VA's Major IT Projects."

2:00 P.M.; VACO, Room 703

POC: (b)(6)

· March 17, 2017. Willie Clark, Deputy Under Secretary for Field Operations, VBA and Mike Frueh, Chief of Staff, VBA, will provide a briefing to SVAC minority staff regarding mandatory overtime.

2:00 P.M.; Teleconference

POC: (b)(6)

· March 17, 2017. (Postponed - March 14, 2017). Dr. Neil Evans, Co-Director, Connected Health,

VHA will brief the Senate Veterans Affairs Committee on how VA provides mental healthcare to those in rural areas of the country – either through mobile providers or through telemedicine.

3:30 P.M.; VACO 511

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· March 21, 2017. (Tentative). The HVAC EO Subcommittee has informally notified VA it intends to hold a legislative hearing. The only bill on the agenda at this time concerns “official time” and other labor management and personnel matters. VA witnesses have not been established.

Time: TBD.; Room TBD

POC: (b)(6)

· March 22, 2017. Joint Hearing of the House and Senate Committee’s on Veterans’ Affairs to receive the Legislative Presentation of Multiple Veterans Service.

10:00 A.M.; G-50 Dirksen

POC: (b)(6)

· March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans’ Affairs, Subcommittee on Health will conduct an oversight hearing on “Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers.”

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

· March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran’s appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

Time 1:30 pm.; Room: Cannon 334

POC: (b)(6)

· March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

Time 8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.
- H.R. 467 - The VA Scheduling Accountability Act.
- H.R. 907 - The Newborn Care Improvement Act.
- H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
- H.R. 1005 - To improve the provision of adult day health care services for Veterans.
- H.R. 1058 - The VA Provider Equity Act.
- H.R. 1162 - The No Hero Left Untreated Act.
- Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
- Draft Bill - To prohibit smoking in any VHA facility.

· April 5, 2017. (Tentative). The HVAC Disability and Memorial Affairs Subcommittee has informally notified VA it intends to hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

Time TBD; Room TBD

POC: (b)(6)

Tentative Agenda (Couple more bills may come)

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- Draft Bill Beneficial Travel for VBA (authorization fix) will send)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Brownley

Julia

CA

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

O'Rourke

Beto

TX

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bost

Mike

IL

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA

State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA

State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA

State Visit Request

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA

Delaware State Veterans Summit

Sen

McCaskill

Claire

MO

Call

3/21/2017

Arla Harrell Act

Sen

Gillibrand

Kirsten

NY

Call

3/22/2017

Blue Water Navy

Sen

Sanders

Bernie

VT

Meeting

3/23/2017

Privatization, Choice, Drug Costs

(Meeting in Office of Secretary)

Rep

Mast

Brian

FL

Meeting

4/3/2017

Meet & Greet

Sen

Murray

Patty

WA

Call/Meeting

3/8/2017

Caregivers

Rep

Sablan

Gregorio

NMI

Meeting

3/7/2017

Access to Care in the Northern Marianas Islands

Sen

Duckworth

Tammy

IL

Call

3/8/2017

TBD

HVAC Minority Member Retreat

Meeting

(Annapolis)

3/24/2017

SecVA's Way Forward for VA

Rep

McMorris Rogers

Cathy

WA

Meeting

3/24/2017

VA issues and Moving Forward in the 115th

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Sen

Klobuchar

Amy

MN

Call

3/16/2017

Owner: (b)(6) /o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: image001 <extracted>
Last Modified: Thu Mar 16 16:36:51 CDT 2017

image001 <extracted> for Printed Item: 10 (Attachment 1 of 3)
This document contains proprietary information and should not be released, in whole or in part, to non -VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or **competing** Member offices that should not be shared with other congressional entities

Owner: (b)(6) o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: image002.png
Last Modified: Thu Mar 16 16:36:51 CDT 2017

Page 002 of 002
Printed Item # 10 (Attachments 2 of 3)
This information should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or competing Member offices that should not be shared with other entities.
Page 395 of 974

Owner: (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn (b)(6) >
Filename: Stand up -March 17.docx
Last Modified: Thu Mar 16 16:36:51 CDT 2017

FOR INTERNAL USE ONLY

Secretary's Morning Report
Prepared by the Office of Congressional & Legislative Affairs
Friday, March 17, 2017

This document contains proprietary information and should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or **competing** Member offices that should not be shared with other congressional entities

Hot Issues

None

Emerging

None

Congressional Letters and Meeting Requests Received

March 16, 2017. Ranking Member Senator Jon Tester (SVAC), and 17 other Senators expressed concern over sexual harassment reports regarding female service members and Veterans.

- Received March 16, 2017: VAIQ #7781860

Thursday March 16, 2017 Events

March 15, 2017. Barbara Ward, Director, Center for Minority Veterans, briefed Rep. Sanford Bishop (D-GA-02) on services the Center provides and the advisory committee's most recent recommendations from their 2016 annual report.

4:00 P.M.; 2407 Rayburn

POCs: (b)(6) Ca-Asia Lane, 202-226-3844

Summary: Barbara Ward, opened the dialogue providing background knowledge and statute history of the VA Center for Minority Veterans (CMV) and the Advisory Committee on Minority Veterans (ACMV), of which Rep. Bishop stated he was familiar with due to his years of Congressional Black Caucus-Veterans' Braintrust Committee engagement and commitment. In addition, Ms. Ward highlighted the recently published 2017 Minority Veterans Report, which reflects current and future Minority Veterans' demographics and utilization of VA benefits and services. Ms. Ward also covered the CMV strategic plan and current targeted outreach initiatives. She reviewed the role of the Advisory Committee on Minority Veterans and pointed out specific recommendations within the 2016 ACMV report. Rep. Bishop asked questions regarding the ACMV, especially screening and the selection process of committee members, and support from senior VA leadership. Ms. Ward provided assurance that VA senior leadership is critical to and supportive of the ACMV member selection process and that VA leadership value the recommendations submitted annually by the ACMV. In addition to leadership support of the ACMV, Ms. Ward indicated leadership support for the CMV's targeted outreach efforts. Rep. Bishop asked for specific information regarding challenges identified as a result of the 2016 ACMV Report. In response, Ms. Ward and Mr. Newsome (Deputy Director, CMV) referred to the ACMV's recommendations with

FOR INTERNAL USE ONLY

specific attention towards the VA gathering comprehensive demographic (race/ethnicity) data to enhance access to VA benefits and services, and support for the VA Office of Health Equity to identify and address health disparities. Lastly, Rep. Bishop encouraged ensuring that members within the HVAC and Tri-Caucus have access to the 2017 Minority Veterans Report and the 2016 Advisory Committee on Minority Veterans Report.

March 16, 2017. Subject Matter Experts from VBA's Pension and Fiduciary Services had a teleconference with SVAC Minority staff to discuss VA's FY17 legislative proposals on fiduciaries.

12:30 P.M.; Teleconference

POC: (b)(6)

Summary: SVAC Minority staff requested information to gather context on fiduciary misuse and the legislative proposals from the VA. Two of the proposals discussed were on the reissuance of VA benefit payments to all victims of misuse and the exemption to the right to the Financial Privacy Act by fiduciaries of VA beneficiaries. Minority staff indicated that the proposal to reissue VA benefit payments of fiduciary misuse was noncontroversial within the Committee. SVAC minority staff appreciated the call and predicted that these issues will likely be brought up in the near future but did not give a specific timeframe.

March 16, 2017. Dr. Ron Maurer, Acting Deputy Assistant Secretary for Congressional and Legislative Affairs, met with staff from Congressman Brian Mast's (R-FL) office to discuss the recent engagement at the West Palm Beach VAMC.

2:30P.M.; 2184 Rayburn House Office Building

POC: (b)(6)

Summary: Dr. Maurer and the Congressman's staff discussed the Congressman's visit to the West Palm Beach VAMC on Tuesday.

March 16, 2017. Bridget McGregor, RN Manager, HCBS, Patient Care Services and Curtis Jordan, VISN 19 Network Contract Manager provided an overview of the current nursing home situation in Montana to the Senate Veterans Affairs Committee and Senator Tester's State Staff.

3:30 P.M.; 825A Hart

POC: (b)(6)

Summary: SVAC staff is concerned with potential access issues to nursing homes for Veterans in Montana and nationwide because local nursing home companies have reported they are not renewing their contracts because they are unsatisfied with the government's payment rates. The staff asked if VA was working with nursing homes via contracts or provider agreements. Mr. Jordan said that he found it problematic that VA did not use provider agreements. The Senate staff thanked him for his response and stated that they would continue to urge VA to use provider agreements more often. Mr. Curtis also explained the Service Contract Act requires general contractors performing services on contracts to pay service employees in various classes no less than the wage rates and benefits found in the locality which some nursing homes cannot afford. The congressional staff also asked if there are enough contracts in place to meet the demand. Ms. McGregor explained that there are 115 Veterans in nursing homes in Montana across 36 contracts and that there is never a waitlist to gain access to nursing homes. In closing, the congressional staff said the meeting was very helpful and asked

FOR INTERNAL USE ONLY

that VA provide them with a schedule of contract renewals and a description of what is being done at VA Central Office to track access and availability of nursing homes.

Look Ahead- Friday, March 17, 2017

March 17, 2017. Mr. Michael Valentino, Chief Consultant, Pharmacy Benefits Management, will speak with Mr. James Cari, Manager, Legislative Policy and Strategy Development for the U.S. Postal Service, to discuss loss of medications that occur during the shipping process. During the February 27, 2017, Hearing before HVAC-O&I, Dr. Clancy testified that 91.4 percent of reported drug losses occur in the mail (USPS and UPS).

10:00 A.M.; Teleconference

POC: (b)(6)

March 17, 2017. Sean Clark, National Coordinator, Veterans Justice Outreach Program, will brief Representative Coffman's on the Veterans Justice Outreach (VJO) program.

2:00 P.M.; Teleconference

POC: (b)(6)

March 17, 2017. (Continued - March 9, 2017) Rob Thomas, OI&T, Acting Assistant Secretary, provided a briefing to SVAC minority staff on "VA's Major IT Projects."

2:00 P.M.; VACO, Room 703

POC: (b)(6)

March 17, 2017. Willie Clark, Deputy Under Secretary for Field Operations, VBA and Mike Frueh, Chief of Staff, VBA, will provide a briefing to SVAC minority staff regarding mandatory overtime.

2:00 P.M.; Teleconference

POC: (b)(6)

March 17, 2017. (Postponed - March 14, 2017). Dr. Neil Evans, Co-Director, Connected Health, VHA will brief the Senate Veterans Affairs Committee on how VA provides mental healthcare to those in rural areas of the country – either through mobile providers or through telemedicine.

3:30 P.M.; VACO 511

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress
--

March 21, 2017. (Tentative). The HVAC EO Subcommittee has informally notified VA it intends to hold a legislative hearing. The only bill on the agenda at this time concerns "official time" and other labor management and personnel matters. VA witnesses have not been established.

Time: TBD.; Room TBD

POC: (b)(6)

March 22, 2017. Joint Hearing of the House and Senate Committee's on Veterans' Affairs to receive the Legislative Presentation of Multiple Veterans Service.

10:00 A.M.; G-50 Dirksen

FOR INTERNAL USE ONLY

POC: (b)(6)

March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans' Affairs, Subcommittee on Health will conduct an oversight hearing on "Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers."

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

Time 1:30 pm.; Room: Cannon 334

POC: (b)(6)

March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

Time 8:00 A.M.; 334 Cannon

POC: (b)(6)

H.R. 91 - The Building Supportive Networks for Women Veterans Act.

H.R. 95 - The Veterans' Access to Child Care Act.

H.R. 467 - The VA Scheduling Accountability Act.

H.R. 907 - The Newborn Care Improvement Act.

H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.

H.R. 1005 - To improve the provision of adult day health care services for Veterans.

H.R. 1058 - The VA Provider Equity Act.

H.R. 1162 - The No Hero Left Untreated Act.

Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.

Draft Bill - To prohibit smoking in any VHA facility.

April 5, 2017. (Tentative). The HVAC Disability and Memorial Affairs Subcommittee has informally notified VA it intends to hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

Time TBD; Room TBD

POC: (b)(6)

Tentative Agenda (Couple more bills may come)

HR 1328 (Bost)-Auto COLA

HR 1329 (Bost)-Annual COLA

HR 1390 (Banks)-Transportation to State and Tribal Cemeteries

Draft Bill Beneficial Travel for VBA (authorization fix) will send)

HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries

FOR INTERNAL USE ONLY

Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
 HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders
--

Sen/Rep	Last Name	First Name	State	Type of Engagement	Received	Date Scheduled	Topic
Rep	Brownley	Julia	CA	Meeting	3/15/2017		VA Priorities To Be Rescheduled from 3/15
Rep	O'Rourke	Beto	TX	Meeting	3/15/2017		VA Priorities To Be Rescheduled from 3/15
Rep	Bergman	Jack	MI	Meeting	3/15/2017		VA Priorities To Be Rescheduled from 3/15
Rep	Bost	Mike	IL	Meeting	3/15/2017		VA Priorities To Be Rescheduled from 3/15
Sen	Sullivan	Dan	AK	Travel	2/1/2017		SecVA State Visit Request
Sen	Tester	Jon	MT	Travel	2/1/2017		SecVA State Visit Request
Sen	Manchin	Joe	WV	Travel	2/1/2017		SecVA State Visit Request
Sen	Carper	Tom	DE	Travel		4/3/2017	SecVA Delaware State Veterans Summit
Sen	McCaskill	Claire	MO	Call		3/21/2017	Arla Harrell Act
Sen	Gillibrand	Kirsten	NY	Call		3/22/2017	Blue Water Navy
Sen	Sanders	Bernie	VT	Meeting		3/23/2017	Privatization, Choice, Drug Costs (Meeting in Office of Secretary)
Rep	Mast	Brian	FL	Meeting		4/3/2017	Meet & Greet
Sen	Murray	Patty	WA	Call/Meeting	3/8/2017		Caregivers
Rep	Sablan	Gregorio	NMI	Meeting	3/7/2017		Access to Care in the Northern Marianas Islands
Sen	Duckworth	Tammy	IL	Call	3/8/2017		TBD
	HVAC Minority Member Retreat			Meeting (Annapolis)		3/24/2017	SecVA's Way Forward for VA

FOR INTERNAL USE ONLY

Rep	McMorris Rogers	Cathy	WA	Meeting		3/24/2017	VA issues and Moving Forward in the 115 th
Rep	Arrington	Jodey	TX	Meeting	3/14/2017		VA Priorities – Proactive
Sen	Daines	Steve	MT	Travel	1/25/2017		Ft Harrison
Rep	Esty	Elizabeth	CT	Travel	3/15/2017		Newington & Farmington, CT
Rep	Kuster	Ann McClane	NH	Travel	3/15/2017		Nashua, NH Homelessness/Suicide
Sen	Klobuchar	Amy	MN	Call	3/16/2017		Burn Pit Legislation

From: (b)(6) </o=va/ou=vba
philadelphia/cn=recipients/cn (b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Thursday, March 16, 2017
Date: Wed Mar 15 2017 16:44:53 CDT
Attachments: image001
image002.png
Stand up -March 16.docx

All,

Attached is the Morning Report for Thursday, March 16 , 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Thursday, March 16, 2017

Hot Issues

- House floor action expected Thursday, March 16 or Friday, March 17: The House is scheduled to take up the following bills, subject to a process to be established by the House Rules Committee. None of the bills has been the subject of a hearing in the 115th Congress:

H.R. 1181, the Veterans 2nd Amendment Protection Act would prevent the names of Veterans who have been deemed incompetent for VA benefits purposes from being provided to the database used for firearms purchases, unless they have been found by a judicial authority to be a danger to themselves or others;

H.R. 1259, the VA Accountability First Act would establish expedited removal authority for VA employees generally. It also includes measures to recoup relocation expenses and performance awards, allowing direct hiring for VAMC and VISN directors, and reduce benefits for VA employees convicted of certain crimes; and,

H.R. 1367, which has been put forward as an effort to help VA hire and retain VA employees. Among the provisions are measures that would establish a fellowship program to encourage interchange of employees from the private sector, require performance appraisals of political appointees, broaden the application of Veteran's preference in employment, allow speedier hiring of former VA employees, require a central vacancy database, and strengthen training for HR professionals.

Emerging

- None

Congressional Letters and Meeting Requests Received

- March 2, 2017. Chairman David P. Roe (HVAC) requested information in reference to a case at the VA Caribbean Healthcare System.

- o Received March 15, 2017: VAIQ #7781579

- March 13, 2017. Sen. Tammy Baldwin (D-WI) expressed concern about the Choice Program in Wisconsin.

- o Received March 13, 2017: VAIQ #7781469

- March 13, 2017. 10 Members of Congress expressed concern in reference to the GAO, High Risk Series.

- o Received March 13, 2017. VAIQ #7781330

- March 15, 2017. Sen. John Boozman (R-AR) and Rep. French Hill (R-AR) requested VA's plan to resolve the solar panel project at the John L. McClellan Memorial Veterans Hospital in Little Rock, Arkansas.

- o Received March 15, 2017: VAIQ #7781465

Wednesday March 15, 2017 Events

- March 15, 2017. Thomas F. Klobucar, PhD, Acting Director, Office of Rural Health, briefed a Rural Health Care update to the staff of Congressman Tim Walz.

10:00 A.M.; Teleconference

POC: (b)(6)

Summary: Dr. Klobucar walked the Representative Walz's staff through a VA Office of Rural Health 101 brief, highlighting: the office's history, including statute which authorized the establishment of the program as well as recognition of the rural health resource centers; current and impending challenges Vets in rural locations face (#1 is provider and specialist shortages); current rural health initiatives and projections; and rural health solutions within MyVA access initiative. The briefing was well received by the Congressman's office. As VA looks to the future of VA, particularly within the care in the community realm, the Congressman's staff asked that the Office of Rural Health play a major role in those discussions.

- March 15, 2017. Senate Veterans' Affairs Committee held a hearing on Government Accountability Office's (GAO) High Risk List.

Witness: Dr. Carolyn Clancy, Under Secretary for Health for Organizational Excellence

2:30 P.M.; 418 Russell

POC: (b)(6)

Summary: At the opening of the hearing GAO criticized VA for not acting on their recommendations

with a sense of urgency. During her opening remarks, Dr. Clancy countered that VA takes GAO's work seriously and appreciates the advice and feedback VA has received from GAO. VAOIG in their testimony called attention to a few examples of programs that have been vulnerable to waste, fraud, and abuse. Senator Tester was specifically concerned with an OIG report which assessed the extent that patients experienced delays and the impact of any delays on patient outcomes at the VA Montana Health Care System (system), Fort Harrison, MT. Dr. Clancy acknowledged the Senator's concern and not only explained the ways in which the facility is addressing issues, but also explained how the facility was reviewing the root causes of the original issues. Senator Tester expressed satisfaction with the new VA leadership in Montana. A topic of concern for Senator Tillis was the OIG's Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6. Dr. Clancy discussed some of the initiatives implemented within VA since the timeframe of the OIG report. Overall, the duration of the hearing was short and the discussion was not contentious.

· March 15, 2017. Barbara Ward, Director, Center for Minority Veterans, briefed

Rep. Sanford Bishop (D-GA-02) on services the Center provides and the advisory committee's most recent recommendations from their 2016 annual report.

4:00 P.M.; 2407 Rayburn

POCs: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

Look Ahead- Thursday, March 16, 2017

· March 16, 2017. Dr. Neil Evans, Co-Director, Connected Health, VHA will brief the Senate Veterans Affairs Committee on how VA provides mental healthcare to those in rural areas of the country – either through mobile providers or through telemedicine.

3:30 P.M.; Teleconference

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· March 21, 2017. (Tentative). The HVAC EO Subcommittee has informally notified VA it intends to hold a legislative hearing. The only bill on the agenda at this time concerns "official time" and other labor management and personnel matters. VA witnesses have not been established.

Time: TBD.; Room TBD

POC: (b)(6)

- March 22, 2017. Joint Hearing of the House and Senate Committee's on Veterans' Affairs to receive the Legislative Presentation of Multiple Veterans Service.

10:00 A.M.; G-50 Dirksen

POC: (b)(6)

- March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans' Affairs, Subcommittee on Health will conduct an oversight hearing on "Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers."

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

- March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

Time 1:30 pm.; Room: Cannon 334

POC: (b)(6)

- March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

Time 8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.
- H.R. 467 - The VA Scheduling Accountability Act.
- H.R. 907 - The Newborn Care Improvement Act.
- H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
- H.R. 1005 - To improve the provision of adult day health care services for Veterans.
- H.R. 1058 - The VA Provider Equity Act.

- H.R. 1162 - The No Hero Left Untreated Act.
- Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
- Draft Bill - To prohibit smoking in any VHA facility.

· April 5, 2017. (Tentative). The HVAC Disability and Memorial Affairs Subcommittee has informally notified VA it intends to hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

Time TBD; Room TBD

POC: (b)(6)

Tentative Agenda (Couple more bills may come)

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- Draft Bill Beneficial Travel for VBA (authorization fix) will send)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Brownley

Julia

CA

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

O'Rourke

Beto

TX

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bost

Mike

IL

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA

State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA

State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA

State Visit Request

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA

Delaware State Veterans Summit

Sen

McCaskill

Claire

MO

Call

3/21/2017

Arla Harrell Act

Sen

Gillibrand

Kirsten

NY

Call

3/22/2017

Blue Water Navy

Sen

Sanders

Bernie

VT

Meeting

3/23/2017

Privatization, Choice, Drug Costs

(Meeting in Office of Secretary)

Rep

Mast

Brian

FL

Meeting

4/3/2017

Meet & Greet

Sen

Murray

Patty

WA

Call/Meeting

3/8/2017

Caregivers

Rep

Sablan

Gregorio

NMI

Meeting

3/7/2017

Access to Care in the Northern Marianas Islands

Sen

Duckworth

Tammy

IL

Call

3/8/2017

TBD

HVAC Minority Member Retreat

Meeting

(Annapolis)

3/24/2017

SecVA's Way Forward for VA

Rep

McMorris Rogers

Cathy

WA

Meeting

3/24/2017

VA issues and Moving Forward in the 115th

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Owner: (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)>
Filename: image001 <extracted>
Last Modified: Wed Mar 15 16:44:53 CDT 2017

image001 <extracted> for Printed Item: 14 (. Attachment 1 of 3)
This document contains proprietary information and should not be released, in whole or in part, to non -VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or **competing** Member offices that should not be shared with other congressional entities

Owner: (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: image002.png
Last Modified: Wed Mar 15 16:44:53 CDT 2017

Page 002 of 003
Printed Item 14 (Attachments 2 of 3)
This information should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or competing Member offices that should not be shared with other entities.
Page 419 of 974

Owner: (b)(6) /o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: Stand up -March 16.docx
Last Modified: Wed Mar 15 16:44:53 CDT 2017

FOR INTERNAL USE ONLY

Secretary's Morning Report
Prepared by the Office of Congressional & Legislative Affairs
Thursday, March 16, 2017

This document contains proprietary information and should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or **competing** Member offices that should not be shared with other congressional entities

Hot Issues

House floor action expected Thursday, March 16 or Friday, March 17: The House is scheduled to take up the following bills, subject to a process to be established by the House Rules Committee. None of the bills has been the subject of a hearing in the 115th Congress:

H.R. 1181, the Veterans 2nd Amendment Protection Act would prevent the names of Veterans who have been deemed incompetent for VA benefits purposes from being provided to the database used for firearms purchases, unless they have been found by a judicial authority to be a danger to themselves or others;

H.R. 1259, the VA Accountability First Act would establish expedited removal authority for VA employees generally. It also includes measures to recoup relocation expenses and performance awards, allowing direct hiring for VAMC and VISN directors, and reduce benefits for VA employees convicted of certain crimes; and,

H.R. 1367, which has been put forward as an effort to help VA hire and retain VA employees. Among the provisions are measures that would establish a fellowship program to encourage interchange of employees from the private sector, require performance appraisals of political appointees, broaden the application of Veteran's preference in employment, allow speedier hiring of former VA employees, require a central vacancy database, and strengthen training for HR professionals.

Emerging

None

Congressional Letters and Meeting Requests Received

March 2, 2017. Chairman David P. Roe (HVAC) requested information in reference to a case at the VA Caribbean Healthcare System.

- Received March 15, 2017: VAIQ #7781579

March 13, 2017. Sen. Tammy Baldwin (D-WI) expressed concern about the Choice Program in Wisconsin.

- Received March 13, 2017: VAIQ #7781469

March 13, 2017. 10 Members of Congress expressed concern in reference to the GAO, High Risk Series.

FOR INTERNAL USE ONLY

- Received March 13, 2017. VAIQ #7781330

March 15, 2017. Sen. John Boozman (R-AR) and Rep. French Hill (R-AR) requested VA's plan to resolve the solar panel project at the John L. McClellan Memorial Veterans Hospital in Little Rock, Arkansas.

- Received March 15, 2017: VAIQ #7781465

Wednesday March 15, 2017 Events

March 15, 2017. Thomas F. Klobucar, PhD, Acting Director, Office of Rural Health, briefed a Rural Health Care update to the staff of Congressman Tim Walz.

10:00 A.M.; Teleconference

POC: (b)(6)

Summary: Dr. Klobucar walked the Representative Walz's staff through a VA Office of Rural Health 101 brief, highlighting: the office's history, including statute which authorized the establishment of the program as well as recognition of the rural health resource centers; current and impending challenges Vets in rural locations face (#1 is provider and specialist shortages); current rural health initiatives and projections; and rural health solutions within MyVA access initiative. The briefing was well received by the Congressman's office. As VA looks to the future of VA, particularly within the care in the community realm, the Congressman's staff asked that the Office of Rural Health play a major role in those discussions.

March 15, 2017. Senate Veterans' Affairs Committee held a hearing on Government Accountability Office's (GAO) High Risk List.

Witness: Dr. Carolyn Clancy, Under Secretary for Health for Organizational Excellence

2:30 P.M.; 418 Russell

POC: (b)(6)

Summary: At the opening of the hearing GAO criticized VA for not acting on their recommendations with a sense of urgency. During her opening remarks, Dr. Clancy countered that VA takes GAO's work seriously and appreciates the advice and feedback VA has received from GAO. VAOIG in their testimony called attention to a few examples of programs that have been vulnerable to waste, fraud, and abuse. Senator Tester was specifically concerned with an OIG report which assessed the extent that patients experienced delays and the impact of any delays on patient outcomes at the VA Montana Health Care System (system), Fort Harrison, MT. Dr. Clancy acknowledged the Senator's concern and not only explained the ways in which the facility is addressing issues, but also explained how the facility was reviewing the root causes of the original issues. Senator Tester expressed satisfaction with the new VA leadership in Montana. A topic of concern for Senator Tillis was the OIG's Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6. Dr. Clancy discussed some of the initiatives implemented within VA since the timeframe of the OIG report. Overall, the duration of the hearing was short and the discussion was not contentious.

March 15, 2017. Barbara Ward, Director, Center for Minority Veterans, briefed Rep. Sanford Bishop (D-GA-02) on services the Center provides and the advisory committee's most recent recommendations from their 2016 annual report.

FOR INTERNAL USE ONLY

4:00 P.M.; 2407 Rayburn

POCs: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

Look Ahead- Thursday, March 16, 2017

March 16, 2017. Dr. Neil Evans, Co-Director, Connected Health, VHA will brief the Senate Veterans Affairs Committee on how VA provides mental healthcare to those in rural areas of the country – either through mobile providers or through telemedicine.

3:30 P.M.; Teleconference

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

March 21, 2017. (Tentative). The HVAC EO Subcommittee has informally notified VA it intends to hold a legislative hearing. The only bill on the agenda at this time concerns “official time” and other labor management and personnel matters. VA witnesses have not been established.

Time: TBD.; Room TBD

POC: (b)(6)

March 22, 2017. Joint Hearing of the House and Senate Committee's on Veterans' Affairs to receive the Legislative Presentation of Multiple Veterans Service.

10:00 A.M.; G-50 Dirksen

POC: (b)(6)

March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans' Affairs, Subcommittee on Health will conduct an oversight hearing on “Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers.”

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

Time 1:30 pm.; Room: Cannon 334

POC: (b)(6)

March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

Time 8:00 A.M.; 334 Cannon

POC: (b)(6)

FOR INTERNAL USE ONLY

H.R. 91 - The Building Supportive Networks for Women Veterans Act.
H.R. 95 - The Veterans' Access to Child Care Act.
H.R. 467 - The VA Scheduling Accountability Act.
H.R. 907 - The Newborn Care Improvement Act.
H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
H.R. 1005 - To improve the provision of adult day health care services for Veterans.
H.R. 1058 - The VA Provider Equity Act.
H.R. 1162 - The No Hero Left Untreated Act.
Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
Draft Bill - To prohibit smoking in any VHA facility.

April 5, 2017. (Tentative). The HVAC Disability and Memorial Affairs Subcommittee has informally notified VA it intends to hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

Time TBD; Room TBD

POC: (b)(6)

Tentative Agenda (Couple more bills may come)

HR 1328 (Bost)-Auto COLA
 HR 1329 (Bost)-Annual COLA
 HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
 Draft Bill Beneficial Travel for VBA (authorization fix) will send
 HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
 Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
 HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders
--

Sen/Rep	Last Name	First Name	State	Type of Engagement	Received	Date Scheduled	Topic
Rep	Brownley	Julia	CA	Meeting	3/15/2017		VA Priorities To Be Rescheduled from 3/15
Rep	O'Rourke	Beto	TX	Meeting	3/15/2017		VA Priorities To Be Rescheduled from 3/15
Rep	Bergman	Jack	MI	Meeting	3/15/2017		VA Priorities To Be Rescheduled from 3/15
Rep	Bost	Mike	IL	Meeting	3/15/2017		VA Priorities To Be Rescheduled from 3/15
Sen	Sullivan	Dan	AK	Travel	2/1/2017		SecVA State Visit Request
Sen	Tester	Jon	MT	Travel	2/1/2017		SecVA

FOR INTERNAL USE ONLY

							State Visit Request
Sen	Manchin	Joe	WV	Travel	2/1/2017		SecVA State Visit Request
Sen	Carper	Tom	DE	Travel		4/3/2017	SecVA Delaware State Veterans Summit
Sen	McCaskill	Claire	MO	Call		3/21/2017	Arla Harrell Act
Sen	Gillibrand	Kirsten	NY	Call		3/22/2017	Blue Water Navy
Sen	Sanders	Bernie	VT	Meeting		3/23/2017	Privatization, Choice, Drug Costs (Meeting in Office of Secretary)
Rep	Mast	Brian	FL	Meeting		4/3/2017	Meet & Greet
Sen	Murray	Patty	WA	Call/Meeting	3/8/2017		Caregivers
Rep	Sablan	Gregorio	NMI	Meeting	3/7/2017		Access to Care in the Northern Marianas Islands
Sen	Duckworth	Tammy	IL	Call	3/8/2017		TBD
	HVAC Minority Member Retreat			Meeting (Annapolis)		3/24/2017	SecVA's Way Forward for VA
Rep	McMorris Rogers	Cathy	WA	Meeting		3/24/2017	VA issues and Moving Forward in the 115 th
Rep	Arrington	Jodey	TX	Meeting	3/14/2017		VA Priorities – Proactive
Sen	Daines	Steve	MT	Travel	1/25/2017		Ft Harrison

From: (b)(6) (b)(6) H. </o=va/ou=external
(fydibohf25spdlt)/cn=recipients/cn=4d8a7c9a01344bda871253b4f505
a8b5>
To: DJS </o=va/ou=exchange administrative
group (fydibohf23spdlt)/cn=recipients/cn=(b)(6)>
Cc: (b)(6) (b)(6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b)(6)>
Bcc:
Subject: updated draft
Date: Wed Mar 28 2018 08:43:27 CDT
Attachments: VA Care Perspective_R1_03.28.18.docx
VA Care Perspective_Responses_03.28.18.docx

Dr. Shulkin,

Updated draft with itemized responses to reviewer comments included. Once I hear from you, and we are satisfied with the revisions, I will send to (b)(6) and (b)(6)

(b)(6)

Owner: (b)(6) (b)(6) H. </o=va/ou=external (fydibohf25spdl)
/cn=recipients/cn=4d8a7c9a01344bda871253b4f505a8b5>
Filename: VA Care Perspective_R1_03.28.18.docx
Last Modified: Wed Mar 28 08:43:27 CDT 2018

DRAFT - NOT FOR COPY, NOT FOR DISTRIBUTION

Why VA Needs More Competition

Kyle H. Sheetz, MD, MSc¹ and David J. Shulkin, MD¹

¹Department of Veterans Affairs, Washington, D.C.
(Revised Draft)

Corresponding Author:

Kyle H. Sheetz, M.D., M.Sc.
Department of Veterans Affairs
810 Vermont Avenue NW
Office 861
Washington, D.C. 20005

The authors do not report any conflicts of interest related to the content of this manuscript.

DRAFT - NOT FOR COPY, NOT FOR DISTRIBUTION

Independent studies show that clinical quality in the Department of Veterans Affairs (VA) health system is as good or better than in the private sector.¹⁻⁴ While numerous areas for improvement still exist^{5,6}, it is imperative that efforts to reform VA focus on building systems that ensure high quality standards in VA medical centers and from private sector providers who increasingly care for veterans. VA has long-relied on the private sector to expand its capacity and to meet veterans' health care needs. Private sector providers are often the only practical option for a veteran living in rural areas or for those requiring specialty services not offered by their local VA medical center.

In 2014 Congress created the VA Choice Program, expanding community resources and giving more veterans the option to seek care in the private sector. This led to a 76% increase in clinical episodes by non-VA providers and has allowed over 1.7 million veterans to receive care through this program. In 2015, reflecting on the experience of the Choice Program, VA began planning for the future – where VA and private sector providers compete on quality and outcomes within high-performing networks.⁷ Under this model, adequate funding is necessary for VA to modernize its delivery system and ensure that sufficient clinical resources remain available to all veterans. Though some view this as a step towards VA privatization, others characterize it as an innovative solution to maximize resources and promote higher quality care.

Competition is an improvement strategy for VA, not a privatization strategy, and it is also a driving force for innovation in the private sector. When hospitals fail to provide better quality or customer service than their competitors, patients can vote with their feet. Competition may therefore be the most effective way for VA to improve quality standards and ensure that veterans have access to the timeliest and highest quality care available. Providing veterans with greater choice will likely expose VA medical centers to novel market forces that can then promote new advancements in quality, safety, and value for the customer, both in and out of VA.

Most studies of United States' health care markets suggest that higher competition drives improvements in quality and also lowers prices.⁸ However, the dynamics within other markets may also

DRAFT - NOT FOR COPY, NOT FOR DISTRIBUTION

offer insight into the specific challenges faced by VA. The United Kingdom's National Health Service (NHS), a single-payer and fixed-cost delivery system, has been similarly criticized for problems related to access and quality. In 2006, the NHS initiated a pro-competitive policy requiring beneficiaries to be given a choice of different hospitals when seeking care. Hospitals were paid fixed, regulated prices for services rendered. Though controversial, there were several important consequences of this policy.⁹ Hospital competition increased as a result of the policy – even in rural areas that tended to have fewer providers. Furthermore, hospitals exposed to higher competition had the largest improvements in clinical quality for various conditions, such as acute myocardial infarction.¹⁰ Countries with similar delivery systems, such as Canada and Australia, have also explored policies to improve timeliness and quality by introducing more competition.

Competition may be particularly important in efforts to modernize VA. Unlike private sector hospitals, VA medical centers operate under a fixed-cost model, where increases in clinical productivity are not directly linked to higher hospital revenues. Furthermore, VA medical centers have not traditionally competed for market share or the ability to develop specific clinical programs. VA medical centers do have a long history of innovation and continuous quality improvement. However, these efforts traditionally focus on internal benchmarks and comparisons, which have become increasingly disconnected from performance standards in the private sector. In that setting, providers and hospitals are exposed to numerous risks when service quality is diminished (e.g. loss of referrals or direct financial risk under alternative payment models). Optimizing research and development with the best tools from VA and the private sector not only creates a world-class quality measurement system, but also pushes innovation in both sectors.

Competition also creates a demand for greater transparency. Veterans deserve accurate and actionable information on the quality of VA care and care from private sector providers. This is particularly important to ensure quality for services like post-traumatic stress disorder (PTSD) treatment and battlefield injuries, which represent a unique clinical need for veterans. With a commitment to

DRAFT - NOT FOR COPY, NOT FOR DISTRIBUTION

transparency, VA publicly reports its clinical outcomes, patient satisfaction, opioid prescribing rates, and appointment wait times. These efforts build on a growing body of evidence suggesting that transparency of quality data improves health systems' performance.¹¹

VA is introducing strategic competition in several ways. First, VA is ensuring that domains of quality, clinical or otherwise, are monitored with precision and accuracy. VA has extensive experience measuring clinical access and patient safety data, but now also tracks administrative activities, leadership vacancies, and employee engagement within each medical center. Building on these data, VA is introducing the Healthcare Improvement Center (HIC), where predictive analytics will help to identify early warning signs or concerning trends. Medical centers will be able to identify potential problems earlier and at more actionable levels. For example, the HIC will provide medical centers with real-time information at the level of specific clinical services (e.g. inpatient general medicine) or within hospitals' patient care workforce (e.g. nursing shortages). While these efforts serve a particular purpose for VA, they also represent a model from which the private sector can standardize new quality benchmarks for health care delivery and administrative effectiveness.

Second, VA is working to optimize regionally oriented networks of community-based providers and medical centers. Networks are designed to reflect the specific needs of each region and, as a result, contain different combinations of generalists and specialists. This will allow veterans and their doctors to compare outcomes between private sector providers and VA. Moving beyond the current framework centered on access standards, VA seeks to allow patients to utilize the network when specific quality metrics fall below private sector performance or the regional standard of care. For example, if physician turnover or nursing shortages increase adverse events on an inpatient general medicine service, veterans could be offered the ability to receive care in the community. Alternatively, if similar issues reduce quality in the private sector, referrals would reflect VA's preference to maximize higher-quality resources within our own system. To be clear, the goal is not an absolute increase in utilization of private sector services. Strategic, rather than unregulated, utilization of the high-performing network ensures that

DRAFT - NOT FOR COPY, NOT FOR DISTRIBUTION

neither the veteran, nor the medical center, lose the ability to coordinate care and ensure the delivery of quality outcomes.

Third, VA is implementing a more deliberate approach in dealing with low-performing VA hospitals. This includes more targeted interventions, time limited action plans with corresponding benchmarks, and specific management consequences if improvements are not realized. This is essential to ensure that the clinical services remain competitive with the private sector. Finally, VA will decentralize decision-making. Medical centers need greater flexibility and responsibility to balance utilization of the care network with longitudinal strategic planning.

All of this is predicated on the need for sufficient resources to modernize VA facilities, technologies, and management practices. VA needs legislative assistance so that it can move towards internal and external pay-for-performance systems and the ability to more fluidly match services with patient activity or demand. This will allow VA to reinvest in itself when more veterans demand its services. It will also allow the system to right size if there are situations where fewer veterans receive their care within VA.

There are close to 20 million veterans across the United States and over 9 million depend on VA care. VA is an essential resource for those who have served our country. Privatization of VA by means of unregulated access to private sector providers is not feasible, necessary, or the best way to care for veterans. While competition alone is not sufficient to improve quality, it can help to modernize performances standards and lead to new management practices within VA medical centers. It can also ensure that private sector providers who wish to care for veterans adhere to the highest quality standards. Legislation to formalize this as the new standard of care is, in its simplest form, how the modern VA can better meet its responsibility to veterans and taxpayers. Veterans deserve a dynamic health care system that is continually improving. The best way to ensure that veterans receive the highest quality and most timely care may be to support the VA at levels that allow it to successfully compete with the private sector.

DRAFT - NOT FOR COPY, NOT FOR DISTRIBUTION

References:

1. Barnett PG, Hong JS, Carey E, Grunwald GK, Joynt Maddox K, Maddox TM. Comparison of Accessibility, Cost, and Quality of Elective Coronary Revascularization Between Veterans Affairs and Community Care Hospitals. *JAMA Cardiol* 2018.
2. Jha AK, Perlin JB, Kizer KW, Dudley RA. Effect of the transformation of the Veterans Affairs Health Care System on the quality of care. *The New England journal of medicine* 2003;348:2218-27.
3. Keating NL, Landrum MB, Lamont EB, et al. Quality of care for older patients with cancer in the Veterans Health Administration versus the private sector: a cohort study. *Annals of internal medicine* 2011;154:727-36.
4. O'Hanlon C, Huang C, Sloss E, et al. Comparing VA and Non-VA Quality of Care: A Systematic Review. *J Gen Intern Med* 2017;32:105-21.
5. Phillips D. At Veterans Hospital in Oregon, a Push for Better Ratings Puts Patients at Risk, Doctors Say. *New York Times* 2018.
6. General OotI. Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6. In: Affairs V, ed.2016.
7. Shulkin DJ. Beyond the VA Crisis--Becoming a High-Performance Network. *The New England journal of medicine* 2016;374:1003-5.
8. Gaynor M. Competition policy in health care markets: navigating the enforcement and policy maze. *Health affairs* 2014;33:1088-93.
9. Gaynor M, Moreno-Serra R, Propper C. Can competition improve outcomes in UK health care? Lessons from the past two decades. *J Health Serv Res Policy* 2012;17 Suppl 1:49-54.
10. Cooper Z, Gibbons S, Jones S, McGuire A. Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms. *Econ J (London)* 2011;121:F228-F60.
11. Fung CH, Lim YW, Mattke S, Damberg C, Shekelle PG. Systematic review: the evidence that publishing patient care performance data improves quality of care. *Annals of internal medicine* 2008;148:111-23.

Owner: (b)(6) (b)(6) H. </o=va/ou=external (fydibohf25spdl)
/cn=recipients/cn=4d8a7c9a01344bda871253b4f505a8b5>
Filename: VA Care Perspective_Responses_03.28.18.docx
Last Modified: Wed Mar 28 08:43:27 CDT 2018

March XX, 2018

Editorial Board
The New England Journal of Medicine
10 Shattuck Street
Boston, MA 02115

Dear Editors,

Thank you for the careful review of our article. We believe that the reviewers' concerns are appropriate, fair, and that addressing them improves the clarity of the message. Below you will find our itemized responses to each reviewer.

We appreciate your ongoing consideration of this *Perspective* for the *NEJM*.

Sincerely,

David J. Shulkin, M.D.
Secretary, Department of Veterans Affairs

Reviewer 1:

This piece provides a helpful summary for NEJM readers about some of the ideas being pursued by VA leaders about how to assure that veterans receive high quality care. It is also nice to hear about some of the changes in store to reflect a desire for continued improvement in the quality of care in the VA and the efficient operations of the VA health care system. Nevertheless, this piece seems quite one-sided about the potential for competition to improve care, without acknowledging some of the concerns that have been voiced about expanding the role of private-sector providers in the VA health care system. Such concerns include the consistent evidence that in the VA system, veterans receive care that is of high quality, highly coordinated and with less use of low-value care; in fact, the VA has been well ahead of the private sector in quality measurement and improvement. Moreover, there is concern that shifting veterans and resources from the high-performing VA to the private sector will weaken the infrastructure and workforce such that the high levels of care cannot be maintained. Finally, there is no guarantee that veterans will get better care outside of the VA, and substantial concern that in a non-integrated system that is structured on a fee-for-service engine, veterans could be at much higher risk for overuse of low-value and poorly coordinated care.

In addition, although the idea of the VA and private sector competing on quality and outcomes is appealing, the current state of quality/outcomes measurement and risk adjustment raise substantial questions about the feasibility of such competition. This should at least be acknowledged.

- Thank you for the careful evaluation of this manuscript. Both you and reviewer 2 had similar concerns regarding overall quality in the VA system relative to the private sector. Both also expressed a specific concern that greater competition in the absence of appropriate quality measurement could actually result in *worse* care for veterans. In addressing many of the specific comments below, we believe that the revised manuscript reflects our complete agreement with the reviewers on this issue and a more careful explanation for how competition may be used to improve quality within the VA.

Specific comments:

Page 2, line 22. The VA choice program has allowed over 1.7 million veterans to receive care, but not necessarily care “that they need.” There is vast amounts of evidence of overuse of low-value care in the private sector.

- This is a great point. We have amended this sentence to be “neutral” with respect to the necessity of care.

Page 3, lines 26-29: Do the authors have evidence to support the statement that the VA’s innovation and quality improvement “efforts traditionally focus on internal benchmarks and comparisons, which have become increasingly disconnected from performance standards in the private sector” and/or that performance standards in the private sector are better (vs. just more easy to measure on a large scale)? The VA collects data that other parts of the health care system that are integrated systems cannot collect, such as surveys of bereaved family members after a veterans’ death, which provide valuable data.

- True, VA collects a significant amount of data that most private sector health systems do not. We describe some of this data, including valuable survey data as you have mentioned, in the paragraph that discusses the value of the new Healthcare Improvement Center (HIC).

That being said, our intent with this specific argument was to show that the repercussions of this “disconnect” are what is truly out of line with the private sector. In other words, changes in quality for private sector providers/hospitals place them at risk across several domains. For example, trends toward lower quality services may result in changes to valuable referral patterns and/or direct financial risk from quality driven alternative payment models. The same is not true for the VA system. We have amended this paragraph to reflect the important nature of this critique.

Page 3, lines 45-56. These efforts to further track care delivery and administrative activities and leadership are exciting and should serve as a model for the private sector (as has been the case with other quality measurement and improvement activities. But it is not entirely clear to me how this description follows the topic sentence about how VA is introducing strategic competition. Are the authors making the point that non-VA health care organizations should do the same?

- This is another important question that deserves further clarification on our part. We are not making the argument that the strategic competition should be the model for the private sector. Qualifying competition as “strategic” is intended to limit the extent to which this model can be (mis)interpreted as full-scale privatization of VA. We do, however, agree with you that private sector hospitals and health systems should adopt similar data collection strategies related to care delivery and administrative effectiveness. In this scenario, it would allow for the development of new quality benchmarks related to the increasingly complex administrative side of healthcare. We have amended this paragraph to address your question and these discussion points.

Page 4, lines 10-29. Can the authors say more about the “regionally oriented networks of community-based providers”? Does this include both hospitals and physicians? Are the physicians primarily specialists? What types of outcome data and quality metrics will be available for comparisons? Is there a vision for how the coordination of care with providers in the VA will be maintained?

- An important question – these network include physicians and hospitals. They are designed to reflect the overall needs of the region. For that reason, they include both generalists and specialists. We have amended this paragraph to include a more detailed description of the networks and to emphasize that their capabilities may differ based on the needs of veterans in that geographic location.

Reviewer 2:

The authors make an interesting argument about how private sector competition may help VA improve and become a stronger organization. While in principal this may be true, in practice that can only happen under two circumstances: 1) The VA is funded at a level that allows it to provide needed care to Veterans and allowed to modernize its organization to be more nimble at hiring, contracting and using its resources; and 2) the private sector can provide comparable or better quality of care as the VA. If both these premises are not true, then opening up the VA to competition can worsen quality of care for veterans. This perspective should be strengthened by stressing in particular what needs to be done to ensure that veterans get superb care, regardless of where they seek it; and that the VA is funded at a level that allows it to ensure that high standard. My more specific recommendations follow:

- Thank you for the careful evaluation and honest criticism of the article. In addition to the specific comments below, we made several edits to address (1) funding levels for the VA and (2) the potential for harm when executing a system with more private sector competition.

Paragraph 1 (lines 3-16)

The introduction is a bit unclear. The sentence on line 7 starting “That being said....” seems to imply that we need to ensure high quality standards not only in VA, but also in the private sector, if we are to broaden our community network. This is true but it is not clear.

The authors should consider making the first sentence more declarative: “Independent studies show that clinical quality is as good or better..... “

This is true and often overlooked by the many papers critical of the VA. To strengthen this point, cite more recent papers than Jha (2003). For example, there is review by RAND authors in the Journal of General Internal Medicine in July 2016 (O’Hanlon et. al.) showing generally better or similar care to private sector and a paper by Harvard authors in Annals of Internal Medicine in 2011 showing that cancer care in VA was similar or better to private sector (Keating et. al.).

- Your point regarding these citations is well-taken. We have amended the introduction to include these references.

Then, the authors could go on to say something like: While numerous areas for improvement with VA still exist, it is imperative that we as we reform VA we build the systems to ensure high quality standards in both VA medical centers and the private providers who may be increasingly caring for veterans..... This would get at the issue right at the beginning that not only VA needs to improve, but in order to ensure superb medical care for veterans, standards needs to be maintained for everyone and the VA needs to track those standards. (Imagine if the VA referred a patient to an oncologist in the community who didn't follow quality standards; imagine if the VA didn't know about it). If both VA and community care offers high quality care, then that sets the stage for true competition.

- This is an excellent suggestion for the introduction. We have amended the first paragraph to reflect the specifications described in the 3 paragraphs above.

Paragraph 2 (lines 18-31)

The second sentence is unclear. What increased 76%? Visits? Number of patients seen by non-VA providers? How many patients got non-VA care prior to the Choice program (as opposed to the 1.7 million veterans after)? Also, by saying it allowed 1.7 million veterans to receive the care they need it implies that they wouldn't have gotten that care without the Choice program. It allowed 1.7 million veterans to receive care outside of the VA. This sentence needs to be clarified and the language should be made more specific.

- Reviewer 1 had a similar critique. We have amended this sentence to remove any potential for editorializing the need for care and to describe the 76% increase in episodes of care with Choice.

Paragraph 3(lines 33-44)

2nd sentence: Suggest that the sentence starting "Competition..." should refer to the "timeliest and highest quality care available." Providing timely care of low quality will not help veterans.

- Valid point, this change has been made.

3rd sentence, this is another opportunity to stress that competition can improve care in and out of VA. : "...new advancements in quality, safety and value for the customer, both in and out of VA."

- Again, we agree. This change has been made.

Paragraph 5 (page 2, lines 16-33):

The second part of this paragraph assumes that the private sector is doing a better job (overall) with quality monitoring than the VA. While it may be true that the performance monitoring VA has done was not always exactly in line with the private sector, that was partly because VA was actually doing more, and using more robust approaches, to monitor quality, not because it was doing less. Indeed, aligning with what the private sector is doing may make the VA quality monitoring program weaker. I suggest that it would be stronger to state that VA needs to take the best parts of both private sector and internal performance monitoring programs and create a quality monitoring and improvement system that is world-class and pushes innovation in both the private sector and the VA.

- Thank you for this comment. Reviewer 1 had a similar issue with this paragraph. In addition to clarifying out point about internal vs. external benchmarks, we added the content you suggested about incorporating the best of VA and private sector systems.

Paragraph 6 (page 2, lines 35-44):

I agree wholeheartedly with the first sentence, which states that veterans deserve accurate info on quality of VA and private sector providers. The next sentence only talks about VA however. I suggest the authors have an opportunity to at a sentence at the end of that paragraph that states that veterans will deserve

similar quality information from their non-VA providers, including for conditions not as commonly treated outside the VA, such as PTSD and battle related injuries.

- We agree, this was our intent. We also could not agree more with your point about certain services VA considers foundational, and why it is particularly important to ensure quality in either sector for services that veterans need most.

Paragraph 8 (page 3, lines 10-29)

This paragraph again seems to imply that care will always be better in the private sector. It would be ideal to make a counter example as well. For example, after "...veterans could be offered the ability to receive care in the community," the authors could add a sentence that similarly states that if complications from a particular procedure are higher among private sector providers, veterans may preferentially get treatment in VA (or another similar example).

- This is a good point. We have added that sentence to this paragraph.

Paragraph 9 (page 3, lines 31-41)

Similarly, there is an opportunity to stress that VA will also collect data and quality and access within their newly established community networks to ensure that veterans are referred only to sites and doctors that meet quality standards.

- This is an important concept. We believe the edits made to paragraph 7 now address this critique as well.

Paragraph 10 (page 3, lines 43-54)

Adequate funding is extremely important – not only to modernize but to fund sufficient clinical care (doctors, nurses, etc). This point is buried a bit and could be brought out more (and set up in the first paragraph and brought back in the last paragraph).

- We agree. Our intent was to stress the importance of funding. As such this comment is well-received. Based on your suggestion we added content to the introduction to set up this later discussion.

Paragraph 11 (page 4, lines 3-18)

This paragraph creates another opportunity to hit home that what the VA wants is the highest standard of care for veterans, regardless of where they receive their care. Also gives an opportunity to bring back the adequate funding theme. For example, the sentence starting "While competition alone is not sufficient..." focuses only on what competition will do for VA. Competition could also help to ensure that providers in the private sector who wish to serve Veterans adhere to the highest quality standards. I suggest the authors could add this point to that sentence.

- This is very important. Change made.

Finally, I completely agree that veterans deserve a dynamic health care system that is continually improving. They also deserve to get the highest quality and most timely care whether it is within or outside the VA. I suggest that the last sentence could bring all the points made above home. Perhaps something like: "The best way to ensure that veterans get the highest quality and most timely care possible may be to support the VA at levels that allow it to successfully compete with the private sector."

- This is a strong recommendation and drives our final point. Thank you again. We have amended the last sentence to reflect your comment.

From: DJS </o=va/ou=exchange administrative
group (fydibohf23spdlt)/cn=recipients/cn=(b)(6)>
To: (b)(6) (b)(6) </o=va/ou=va
martinsburg/cn=recipients/cn=(b)(6)>
Cc:
Bcc:
Subject: FW: Editorial
Date: Mon Mar 12 2018 14:06:04 CDT
Attachments: Care Editorial_cover letter_final.docx
Care Editorial_v9_03.12.18.docx

Print

Sent with Good (www.good.com)

From: (b)(6) (b)(6) H.
Sent: Monday, March 12, 2018 11:58:37 AM
To: DJS
Subject: Editorial

Dr. Shulkin,

Thank you for your edits. Attached is an updated draft. Please let me know what you think.

(b)(6)

Owner: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: Care Editorial_cover letter_final.docx
Last Modified: Mon Mar 12 14:06:04 CDT 2018

March XX, 2018

Editorial Board
The New England Journal of Medicine
10 Shattuck Street
Boston, MA 02115

Dear Dr. Drazen,

The Department of Veterans Affairs is currently working with Congress on legislation that establishes a more modern health care delivery system for veterans. As you know, the VA Choice Program was enacted in 2014 to address the well-publicized access crisis. Since that time VA has been developing community-based provider networks to increase access and expand the scope of services available to veterans.

Despite improvements in access, the degree and extent to which VA uses private sector providers remains controversial. While some this as an unfavorable step towards privatization of VA, others contend that privatization may be the best option moving forward. Neither the Choice Program, nor the proposed legislation in Congress facilitate privatization of the VA. The goal of this *Perspective* is to provide clarity on this issue and to describe VA's position on competition as a strategic tool to improve health care for veterans.

We believe that this work is timely and relevant. We appreciate your consideration of this *Perspective* for the *NEJM*.

Sincerely,

David J. Shulkin, M.D.
Secretary, Department of Veterans Affairs

Owner: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: Care Editorial_v9_03.12.18.docx
Last Modified: Mon Mar 12 14:06:04 CDT 2018

Why VA Needs More Competition

Kyle H. Sheetz, MD, MSc¹ and David J. Shulkin, MD¹

¹Department of Veterans Affairs, Washington, D.C.

Corresponding Author:

Kyle H. Sheetz, M.D., M.Sc.
Department of Veterans Affairs
810 Vermont Avenue NW
Office 861
Washington, D.C. 20005

The authors do not report any conflicts of interest related to the content of this manuscript.

While independent studies show that clinical quality in the Department of Veterans Affairs (VA) health system is as good or better than in the private sector^{1,2}, numerous areas for improvement still exist.^{3,4} That being said, the need to ensure high quality standards for veterans goes beyond the comprehensive care provided at VA medical centers. VA has long-relied on the private sector to expand its capacity and to meet veterans' comprehensive health care needs. Private sector providers are often the only practical option for a veteran living in rural areas or for those requiring specialty services not offered by their local VA medical center.

In 2014 Congress created the VA Choice Program, expanding community resources and giving more veterans the option to seek care in the private sector. This led to a 10% increase in services by non-VA providers and has allowed over 1.6 million veterans to receive the care that they need. In 2015, reflecting on the experience of the Choice Program, VA began planning for the future – where VA and private sector providers compete on quality and outcomes within high-performing networks.⁵ Though some view this as a step towards VA privatization, others characterize it as an innovative solution to maximize resources and promote higher quality care.

Competition for patients is a driving force for innovation in the private sector. When hospitals fail to provide better quality or customer service than their competitors, patients can vote with their feet. Competition may therefore be the most effective way for VA to improve quality standards and ensure that veterans have access to the timeliest care available. Providing veterans with greater choice will likely expose VA medical centers to novel market forces that can then promote new advancements in quality, safety, and value for the customer.

Most studies of United States' health care markets suggest that higher competition drives improvements in quality and also lowers prices.⁶ However, the dynamics within other markets may also offer insight into the specific challenges faced by VA. The United Kingdom's National Health Service (NHS), a single-payer and fixed-cost delivery system, has been similarly criticized for problems related to access and quality. In 2006, the NHS initiated a pro-competitive policy requiring beneficiaries to be given

a choice of different hospitals when seeking care. Hospitals were paid fixed, regulated prices for services rendered. Though controversial, there were several important consequences of this policy.⁷ Hospital competition increased as a result of the policy – even in rural areas that tended to have fewer providers. Furthermore, hospitals exposed to higher competition had the largest improvements in clinical quality for various conditions, such as acute myocardial infarction.⁸ Countries with similar delivery systems, such as Canada and Australia, have also explored policies to improve timeliness and quality by introducing more competition.

Competition may be particularly important in efforts to modernize VA. Unlike private sector hospitals, VA medical centers operate under a fixed-cost model, where increases in clinical productivity are not directly linked to higher hospital revenues. Furthermore, VA medical centers have not traditionally competed for market share or the ability to develop specific clinical programs. VA medical centers do have a long history of innovation and continuous quality improvement. However, these efforts traditionally focus on internal benchmarks and comparisons, which have become increasingly disconnected from performance standards in the private sector. Aligning research, development, and innovation with the private sector may allow VA to remain a robust resource for veterans' health care needs.

Competition also creates a demand for greater transparency. Veterans deserve accurate and actionable information on the quality of VA care and care from private sector providers. With a commitment to transparency, VA publicly reports its clinical outcomes, patient satisfaction, opioid prescribing rates, and appointment wait times. These efforts build on a growing body of evidence suggesting that transparency of quality data improves health systems' performance.⁹

VA is introducing strategic competition in several ways. First, VA is ensuring that domains of quality, clinical or otherwise, are monitored with precision and accuracy. VA has extensive experience measuring clinical access and patient safety data, but now also tracks administrative activities, leadership vacancies, and employee engagement within each medical center. Building on these data, VA is

introducing the Healthcare Improvement Center (HIC), where predictive analytics will help to identify early warning signs or concerning trends. Medical centers will be able to identify potential problems earlier and at more actionable levels. For example, the HIC will provide medical centers with real-time information at the level of specific clinical services (e.g. inpatient general medicine) or within hospitals' patient care workforce (e.g. nursing shortages).

Second, VA is working to optimize regionally oriented networks of community-based providers around existing medical centers. This will allow veterans and their doctors to compare outcomes between private sector providers and VA. Moving beyond the current framework centered on access standards, VA seeks to allow patients to utilize the network when specific quality metrics fall below private sector performance or the regional standard of care. For example, if physician turnover or nursing shortages increase adverse events on an inpatient general medicine service, veterans could be offered the ability to receive care in the community. To be clear, the goal is not an absolute increase in utilization of private sector services. Strategic, rather than unregulated, utilization of the high-performing network ensures that neither the veteran, nor the medical center, lose the ability to coordinate care and ensure the delivery of quality outcomes.

Third, VA is implementing a more deliberate approach in dealing with low-performing VA hospitals. This includes more targeted interventions, time limited action plans with corresponding benchmarks, and specific management consequences if improvements are not realized. This is essential to ensure that the clinical services remain competitive with the private sector. Finally, VA will decentralize decision-making. Medical centers need greater flexibility and responsibility to balance utilization of the care network with longitudinal strategic planning.

All of this is predicated on the need for sufficient resources to modernize VA facilities, technologies, and management practices. VA needs legislative assistance so that it can move towards internal and external pay-for-performance systems and the ability to more fluidly match services with patient activity or demand. This will allow VA to reinvest in itself when more veterans demand its

services. It will also allow the system to right size if there are situations where fewer veterans receive their care within VA.

There are close to 20 million veterans across the United States and over 9 million depend on VA care. VA is an essential resource for those who have served our country. Privatization of VA by means of unregulated access to private sector providers is not feasible, necessary, or the best way to care for veterans. While competition alone is not sufficient to improve quality, it can help to modernize performances standards and lead to new management practices within VA medical centers. Legislation to formalize this as the new standard of care is, in its simplest form, how the modern VA can better meet its responsibility to veterans and taxpayers. Veterans deserve a dynamic health care system that is continually improving. The best way to strengthen VA care may be to open it up to competition.

References:

1. Barnett PG, Hong JS, Carey E, Grunwald GK, Joynt Maddox K, Maddox TM. Comparison of Accessibility, Cost, and Quality of Elective Coronary Revascularization Between Veterans Affairs and Community Care Hospitals. *JAMA Cardiol* 2018.
2. Jha AK, Perlin JB, Kizer KW, Dudley RA. Effect of the transformation of the Veterans Affairs Health Care System on the quality of care. *The New England journal of medicine* 2003;348:2218-27.
3. Phillips D. At Veterans Hospital in Oregon, a Push for Better Ratings Puts Patients at Risk, Doctors Say. *New York Times* 2018.
4. General OotI. Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6. In: Affairs V, ed.2016.
5. Shulkin DJ. Beyond the VA Crisis--Becoming a High-Performance Network. *The New England journal of medicine* 2016;374:1003-5.
6. Gaynor M. Competition policy in health care markets: navigating the enforcement and policy maze. *Health affairs* 2014;33:1088-93.
7. Gaynor M, Moreno-Serra R, Propper C. Can competition improve outcomes in UK health care? Lessons from the past two decades. *J Health Serv Res Policy* 2012;17 Suppl 1:49-54.
8. Cooper Z, Gibbons S, Jones S, McGuire A. Does Hospital Competition Save Lives? Evidence from the English NHS Patient Choice Reforms. *Econ J (London)* 2011;121:F228-F60.
9. Fung CH, Lim YW, Mattke S, Damberg C, Shekelle PG. Systematic review: the evidence that publishing patient care performance data improves quality of care. *Annals of internal medicine* 2008;148:111-23.

From: (b)(6)
To: (b)(6)@accenture.com>
Cc: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b)(6)>
Bcc:
Subject: FW: [EXTERNAL] follow up conversations
Date: Mon Feb 05 2018 12:03:10 CST
Attachments: Outline for Shulkin Narrative 01 16 2018.docx

Hi David

I know you will be at HIMSS. I will be there as well. If it works with your schedule we could grab a few minutes around your visit to follow up on this item

Take care

(b)(6) MD JD

Accenture: Insight Driven Health

Chicago, Illinois

EA: (b)(6)

O: (b)(6)

+(b)(6)

M: (b)(6)

(b)(6)@accenture.com

(b)(6)i@accenture.com

From: (b)(6)
Sent: Monday, January 22, 2018 8:00 AM
To: 'vacodjs1@va.gov' <vacodjs1@va.gov>
Cc: (b)(6)@accenturefederal.com>
Subject: RE: [EXTERNAL] follow up conversations

Hi David

As a follow-up to our discussions, I've taken a first cut at an outline and supporting case studies for VA's imperative to use competition and transparency as drivers for continuous improvement. So that we can further refine the piece, I would like to propose a working session. Would it be acceptable for me to coordinate with your team to get us scheduled in the coming weeks?

Thanks,

(b)(6)

(b)(6) MD JD

Accenture: Insight Driven Health

Chicago, Illinois

EA: (b)(6)

O: (b)(6)

(b)(6)

M: (b)(6)@accenture.com

(b)(6)@accenture.com

From: DJS <vacodjs1@va.gov>
Date: December 11, 2017 at 4:03:26 AM PST
To: (b)(6)@accenture.com>
Subject: RE: [EXTERNAL] follow up conversations

That would be great- thanks (b)(6)

Sent with Good (www.good.com)

From: (b)(6)
Sent: Sunday, December 10, 2017 8:38:25 PM
To: Shulkin, David J., MD
Subject: [EXTERNAL] follow up conversations

Hi David

I enjoyed our conversation last week about your effort to use both competition and transparency as tools of continuous improvement. I have seen this strategy used by other public-sector leaders. I would be happy to help you craft a written position supporting this approach. If it is helpful to you I can draft an outline of the rational and find a few supporting case studies. Perhaps I can send you something to look at in the next few weeks and we can get on the phone for a few minutes to see if it helpful.

(b)(6)
MD JD

Senior Managing Director, Global Health
Accenture: Insight Driven Health<<http://www.accenture.com/insightdrivenhealth>>
Chicago, Illinois

O: (b)(6) EA: (b)(6)
M: (b)(6)@accenture.com<mailto:(b)(6)@accenture.com>
(b)(6)@accenture.com<mailto:(b)(6)@accenture.com>

This message is for the designated recipient only and may contain privileged, proprietary, or otherwise confidential information. If you have received it in error, please notify the sender immediately and delete the original. Any other use of the e-mail by you is prohibited. Where allowed by local law, electronic communications with Accenture and its affiliates, including e-mail and instant messaging (including content), may be scanned by our systems for the purposes of information security and assessment of internal compliance with Accenture policy.

www.accenture.com

To comply with certain Department of Defense (DoD) regulations and policies, e-mail communications between Accenture Federal Services (AFS) and Accenture (and its affiliates) are subject to review by designated AFS and DoD personnel.

(b)(6) MD JD

Senior Managing Director, Global Health

Accenture: Insight Driven Health

Chicago, Illinois

O: (b)(6) EA: (b)(6)
M: (b)(6)@accenture.com
(b)(6)@accenture.com

Owner: (b)(6)@accenture.com>
Filename: Outline for Shulkin Narrative 01 16 2018.docx
Last Modified: Mon Feb 05 12:03:10 CST 2018

Narrative outline for Secretary David Shulkin

Using purposeful competition and transparency to drive continuous improvement in the Veterans Health Administration (VHA)

VHA has been a world leading organization in using continuous improvement methods to improve quality of care for Veterans

VHA also has a unique position as the primary and sole provider of healthcare services for Veterans with service connected healthcare conditions

VHA has been able to use this position to be a leader in healthcare information technology such as electronic health records and telemedicine

VHA relies on the private sector to provide approximately one third of the services because it lacks its own capacity but is not direct competition with the private sector

VHA services and patient experience have come under pressure as the demand for its services grows faster than its capacity to meet that demand

VHA needs to find tools to drive continuous improvement in service just as does clinical quality and safety.

Private sector entities that face competition for customers find that competition to be a natural driver of continuous service improvement

Two tools that have been used by other public-sector entities and public utilities that lack natural market competitor are; purposeful competition and transparency

Purposeful competition is competition that is introduced selectively to motivate to public agencies or service providers to improve services for face budget or electoral backlash.

The intent of purposeful competition is not to privatize a public function but rather to stimulate reform of the public service in response

Transparency of activity and performance data has the benefit of both increased trust from the public as well as stimulating leadership to address problems to avoid the public questioning of effective management

Purposeful Competition:

Purposeful competition for the VHA could be built around the research about what people want from a healthcare system

A recent study of how patients chose a health system found that after out of pocket cost the 5 most important factors that matter to patients are trust and respect, multidisciplinary care, shared decision making and experience of the care provider. Much lower is care transitions, waiting times and travel times. (Muhlbacher, A and Schulman, K. Health Services Research April 2016

Similarly, experience design work for patients navigating the health care system find patients seeking simplicity, seamlessness, transparency, security, personalization, coordination (Fjord Era of living services 2015)

Competition along these dimensions are most likely to drive improvement in VHA services that would be deemed as impactful by Veterans

Tom Gash and Theo Roos in the 2012 UK institute for Government, “Choice and Competition in Public Services: Learning From History” reviewed competition efforts instituted by the UK government for Employment services (training and use of sub-contractors) and Social Care (central government gave local government more budgetary control and introduced private competition for nursing home and long term care). A review of these programs concluded that for Employment services, competition with the private sector improved standard in the public sector. For social services, the presence of competition increased citizen satisfaction and innovation. Moreover, uses choice through the creation of personal budgets with public and private sector options proved popular and more cost-effective.

In Phoenix, the city started using private competition for trash collection since the 1970's. The public sector kept losing competitive contracts and city employees learned how to cut costs and compete better. By 2003, the public sector won back the work and has been holding it ever since showing that competition can stimulate private sector to out compete the public sector (Chicago Tribune Sept 30, 2011 Some *Public Workers Win at Managed Competition*)

In Indianapolis in 1997, the mayor issued an RFP for managing maintain and repairing the fleet of city vehicles. The public workers bid on the work against 3 private firms and won, offering to forgo structured pay increases for shared saving where city workers get 25%-30% of the savings as pay increase over 3 years in a performance contract. The city realized \$8M in savings from improved productivity, turnaround time for vehicles decreased and written complaints dropped from 194 a year to 5 within 4 years.

Other Possible Examples from outside the US:

NHS has used competition by creating new competing facilities or permitting private sector services for some primary and specialty services including diagnostic testing and procedures to foster a sense of competition in NHS facilities

Madrid region of Spain the elected leadership wanted the hospitals, public entities, to share information. They faced the usual parochial resistance. They addressed this issue by making consumer choice a political issue and promising citizens the right to go to any public provider. In order to make that possible, the institutions had to create interoperable information systems that would allow information sharing. They did not prescribe the solution but told the facilities however they wanted to solve the problem they needed to get to the same outcome. They made it impossible for the providers to negotiate the ultimate public benefit and as a result drove the organizations to share information to make that choice possible.

Transparency as a tool of public accountability

Transparency has been used as tool to gain both public trust as well as driven accountability into the governance process

The history of transparent hospital outcome measures 20 years ago was rooted in the goal of putting pressure on public board members by showing the facility performance to the community. There was no expectation that patients would mover care from low performing to

high performing facilities and that in fact did not happen. The primary goal was make the board member feel responsible for addressing poor performance measures

A second example is seen in the public posting for healthcare prices. Our research tells us that less than 10% of consumers want to move services from high price to low price but rather to allow consumers to better plan their out of pocket expenses and financial planning (Accenture health POV publication date TBD)

Transparency case studies:

CMS introduced Hospital Compare in 2005 to help consumers make better informed decision about where to seek healthcare. Information on quality, safety, patient perceptions and value were made available. In 2011, a Commonwealth fund study found positive trends in several hospital metrics for 4 years following the introduction of these measures. (Commonwealth fund, New Hospital Compare Measures Help fill out the Performance Picture, Oct 2011)

From: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)/cn=recipients/cn=(b)(6)>
To: (b)(6) </o=va/ou=va martinsburg/cn=recipients/cn=(b)(6)>
Cc:
Bcc:
Subject: FW: small M-H manuscript
Date: Mon Oct 30 2017 07:40:37 CDT
Attachments: Outpatient Access to Care_PS to VA comparison Manuscript_vf_MP.docx
PS_VA_Comparison_wait times_Extended_vf.xlsx

Print

Sent with Good (www.good.com)

From: (b)(6)
Sent: Sunday, October 29, 2017 7:47:14 PM
To: DJS
Subject: FW: small M-H manuscript

Dr. Shulkin—

See attached—Maddie and I wrote up a manuscript on M-H and want to get it out in a journal soon

This is not perfect data and limited in # of specialties—M-H is going to work with us for a better study, but for now I think we should see how this fares in a journal.

Let me know what you think!

Thanks,

(b)(6)

Owner: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: Outpatient Access to Care_PS to VA comparison Manuscript_vf_MP.docx
Last Modified: Mon Oct 30 07:40:37 CDT 2017

Outpatient Access to Care

Wait Time Comparison between the Private Sector and Veterans Administration

Introduction:

In 2014, news broke that the VA facility in Phoenix had altered or destroyed records in an attempt to hide lengthy wait times. This incident damaged credibility and saddled the VA health care system with a reputation for long wait times in the public eye. The negative publicity from a few specific VA facilities has been widely publicized, generating an outsized impact on the overall organization. Since then, the full or partial privatization of the VA health care system has become a major topic of political conversation, with some parties speculating that privatization would increase access and quality of care. Despite this perception, over 22% of VA patients are actually seen on the same day. This paper seeks to make a data-driven comparison of private sector and VA wait times with facts on the ground.

Public perception is that VA health care wait times are inordinately long. In contrast, many believe that private sector wait times are shorter. To our knowledge, no journal has published a rigorous study comparing VA and private sector wait times for outpatient appointments. There is no established benchmark for a “reasonable wait time” for either the private sector or VA. The Department of Veteran Affairs is actually the only health care system in America that transparently tracks and regulates wait times. No other health system in the nation publicly discloses wait time data for clinical appointments. Merritt-Hawkins recently published private sector wait time data collected from a survey. We compared VA to private sector wait times using actual VA data and the recently-published survey on wait times for private sector institutions. Within our analysis, we compared the private sector to the VA, subdividing by years, specialties, and regions. Lastly, in order to liken payment methods, we did a comparison of “safety net regions” (SNR), defined as areas with greater than 50% acceptance of Medicaid, as reported by Merritt-Hawkins.¹ SNR have a more comparable population of patients to VA facilities.

We used the published private sector data from Merritt-Hawkins and VA actual wait time data to address three main questions. First, we analyzed whether outpatient wait times are shorter in VA facilities than in the private sector (using the most recent data from 2017). More specifically, determine in which metropolitan regions, specialties, and safety net regions the VA is faster than, slower than, or the same as the private sector and by how much. Second, we examined how outpatient access compared between the VA facilities and the private sector in the past (using data from 2014). We again analyzed in which metropolitan regions, specialties, and safety net regions were the VA faster than, slower than, or the same as the private sector and by how much. Lastly, we evaluated both the VA’s and

the private sector's improvement in its wait times/outpatient access. We compared whether this progress was more, less, or the same as the private sector, and in which regions and specialties.

Methods:

Merritt-Hawkins, an AMN Healthcare Company, published a survey examining the time needed to schedule a new patient physician appointment in 15 major metropolitan areas and in 15 mid-sized metropolitan areas (of approximately 90,000 to 140,000 people) using the "secret shopper" method of determining wait times. "Secret shopper" is an approach where research associates at Merritt-Hawkins called physician offices in the 30 mid-level and large metropolitan areas with the purpose of scheduling a new patient appointment. In each call, research associates used a script and inquired about the first available time for a new patient appointment. VA collected wait time data from VA facilities and matched them to the metropolitan area in which they reside. VA data reflects the actual times that Veterans waited before seeing a provider. Wait time is equal to the number of days between the day that a Veteran requests an appointment and the date of the appointment. For example: if a patient were to call to schedule an appointment for a new clinic on a Wednesday, and subsequently is scheduled for an appointment on the following Tuesday, then the wait time is computed to six days. This wait time may not always be the earliest available appointment. If a veteran is unavailable or declines the initial earliest available appointment, and asks to be seen at the next earliest availability, this later, but scheduled appointment is the wait time inputted and documented. In contrast, the Merritt-Hawkins script would always yield the earliest available appointment. The private sector to VA comparisons were made between medical facilities in the same metropolitan area, defined within a 50-mile radius.

Analysis:

We conducted an Analysis of Variance (ANOVA) analysis comparing the published private sector average wait times to VA average wait times. The difference between private sector and VA average wait times were evaluated for statistical significance using both a p-test and f-test. Four sets of data sets were compared to answer our three key questions:

- (1) Private sector 2014 average wait times data compared with VA 2014 average.
- (2) Private sector 2017 average wait times compared with VA 2017 average.
- (3) Private sector 2014 average wait times data compared with private sector 2017.
- (4) VA 2014 average wait times data compared with VA 2017 average.

The data from the first two comparisons (between private sector and VA) were further subdivided into metropolitan regions, specialties, and SNRs for additional analysis. Similarly, the data from the second two comparisons (between 2014 and 2017 data) were subdivided into metropolitan areas and specialties. The latter two comparisons were then examined against each other to analyze the difference between private sector and VA improvements over time.

Results:

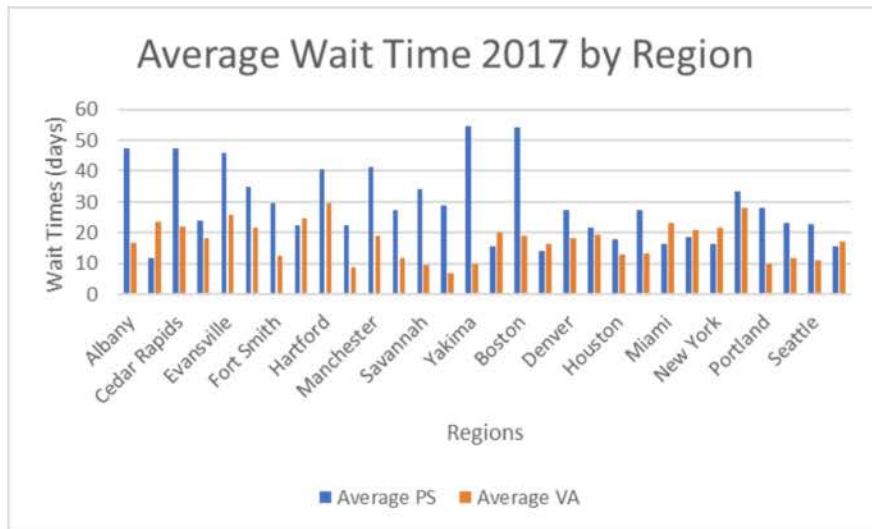
Outpatient wait times shorter in the VA in 2017

Main Takeaways:

1. VA had shorter wait times than private sector (PS) in 73.3% of the metropolitan markets across the four analyzed specialties.
2. VA facilities have statistically significant shorter wait times for three of the four analyzed specialties: cardiology, primary care, and dermatology. VA facilities have statistically significant longer wait times for orthopedics.
3. The difference between average wait times was larger for SNR than the overall results between regions for primary care and dermatology and comparable for cardiology and orthopedics.

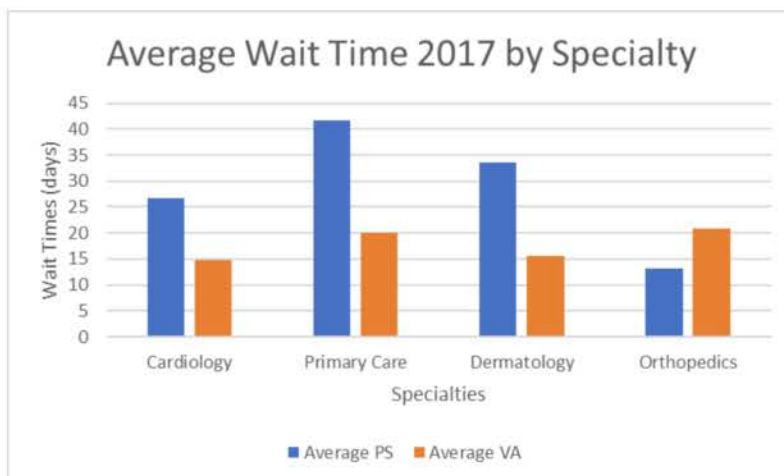
Approximately 87% of VA facilities had available data for all four specialties in 2017. Overall, VA had shorter wait times than the PS in 22 of the 30 metropolitan areas (73.3%) across the four analyzed specialties: Boston, Denver, Detroit, Houston, Los Angeles, Philadelphia, Portland, San Diego, Seattle, Albany, New York; Cedar Rapids, Iowa; Dayton, Ohio; Evansville, Indiana; Fargo, North Dakota; Fort Smith, Arkansas; Hartford, Connecticut; Lafayette, Louisiana; Manchester, New Hampshire; Odessa, Texas; Savannah, Georgia; Temecula, California; and Yakima, Washington (Figure 1).

Figure 1:



VA facilities have statistically significant shorter wait times for three of the four analyzed specialties: cardiology, primary care, and dermatology (Figure 2). For cardiology, the difference in the average wait time between the PS and VA facilities is 11.0 days, 26.0 days (PS) and 15.0 days (VA), with $p < 0.05$ and $F = 9.47 > F_{crit} = 4.02$. For primary care, the difference in the average wait time between the PS and VA facilities was 17.2 days, 39.6 days (PS) and 22.4 days (VA), with $p < 0.05$ and with $F = 9.47 > F_{crit} = 4.02$. For dermatology, the difference in the average wait time between the private sector and VA facilities was 18.1 days, 33.7 days (PS) and 15.6 days (VA), with $p < 0.05$ and with $F = 16.71 > F_{crit} = 4.01$. We found that VA facilities had shorter wait times in 19 of the 24 areas for cardiology, 22 of the 29 areas for primary care, and 24 of the 28 areas for dermatology.

Figure 2:



However, VA facilities had a statistically significant longer wait time for orthopedics. For orthopedics, the difference in the average wait time between the private sector and VA facilities was 6.9 days, 13.2 days (PS) and 20.1 days (VA), with $p < 0.05$ and with $F = 8.09 > F_{crit} = 4.03$. Only 5 of the 23 areas for orthopedics had shorter or equal wait times.

The difference between average wait times was larger for SNR than the overall regional results between regions for primary care and dermatology. For SNR primary care, the difference in the average wait time between the private sector and VA facilities was 26.4 days, 47.9 days (PS) and 21.5 days (VA), with $p < 0.05$. For SNR dermatology, the difference in the average wait time between the private sector and VA facilities was 28.5 days, 39.8 days (PS) and 11.3 days (VA), with $p < 0.05$. The difference between wait times for SNR was comparable to the overall results for cardiology, with the difference in the average wait time between the private sector and VA facilities being 10.1 days, 26.0 days (PS) and 15.9 days (VA), with $p < 0.05$. The difference between wait times for SNR was comparable to the overall results for orthopedics, with the difference in the average wait time between the private sector and VA facilities being 6.9 days, 12.2 days (PS) and 19.1 days (VA), with $p < 0.05$.

Table 1:

Wait Times for PS and VA 2017

	Cardiology		Family Care/Primary Care		Dermatology		Orthopedics		
City	PS	VA	PS	VA	PS	VA	PS	VA	
Albany		10	5	122	39	46	15	11	8
Billings		22	7	7	13	11	7	8	67
Cedar Rapids		10	21	75	23	91		14	
Dayton		21	20	40	21	23	20	12	12
Evansville		30	19	76	14	43	54	34	16
Fargo		39	19	20	19	71	29	10	19
Fort Smith		48	19	37	16	10	3	23	
Hampton		16	5	35	15	25	28	13	51
Hartford		40	19	60	48	47	22	15	
Lafayette		31	10	10	13	38	4	11	
Manchester		46		72		33	15	14	23
Odessa		63		24	12	6		17	
Savannah		36	0	61	23	26	6	14	
Temecula		55		22	9	25	4	13	8
Yakima		18		153	18	31	2	16	
Atlanta		16	42	27	18	13	3	7	19
Boston		45		109	27	52	11	11	19
Dallas		12	11	12	16	22	27	10	11
Denver		22	14	27	19	51	7	10	33
Detroit		14	17	27	13	27	32	19	16
Houston		12	14	21	12	28	11	10	14
Los Angeles		20	2	42	10	35	23	12	19
Miami		14		28	44	11	9	12	17
Minneapolis		22	15	8	13	30	37	15	18
New York		15	11	26	39	15	12	10	25
Philadelphia		28	59	17	26	78	9	10	19
Portland		32	6	39	13	30	8	11	13
San Diego		30	3	13	8	30	20	19	16
Seattle		16	5	26	13	42	16	7	11
Wash. DC		18	10	17	27	20	4	8	27

Table 2:

% Medicaid Acceptance 2017				
City	Cardiology	Primary Care	Dermatology	Orthopedics
Albany	86	90	20	30
Billings	67	100	40	67
Cedar Rapids	100	33	67	60
Dayton	80	100	20	50
Evansville	100	50	20	100
Fargo	100	100	100	100
Fort Smith	80	56	33	100
Hampton	60	40	20	57
Hartford	90	60	80	50
Lafayette	13	20	0	14
Manchester	60	90	67	50
Odessa	20	50	0	0
Savannah	57	50	25	33
Temecula	70	40	60	71
Yakima	100	80	67	50
Atlanta	85	35	15	25
Boston	100	78	70	75
Dallas	15	25	10	20
Denver	83	20	35	35
Detroit	100	71	25	45
Houston	65	30	10	45
Los Angeles	67	45	30	15
Miami	80	40	25	15
Minneapolis	100	100	85	100
New York	50	80	25	20
Philadelphia	94	88	40	81
Portland	100	55	60	55
San Diego	47	33	50	59
Seattle	77	71	10	55
Wash. DC	94	53	10	10

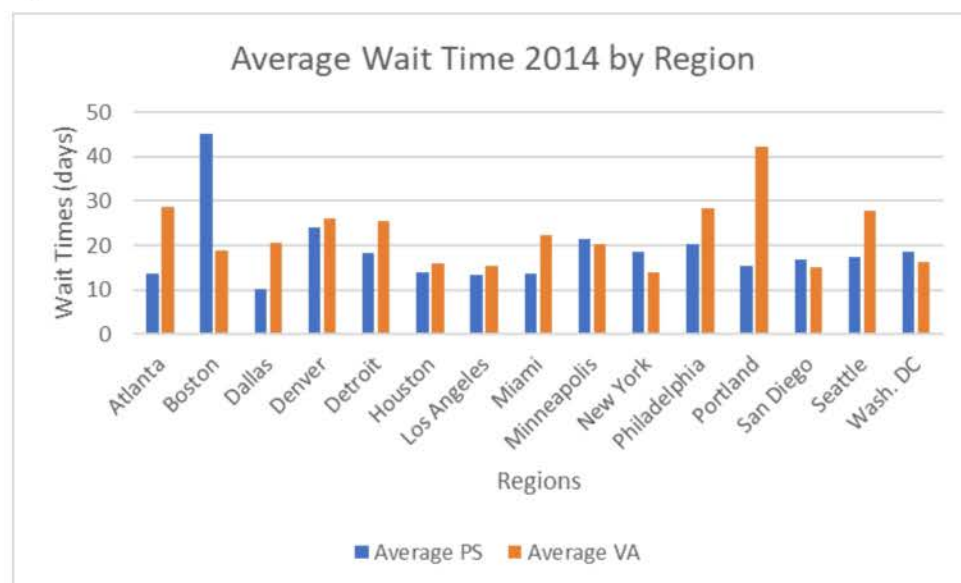
Outpatient wait times shorter in the VA in 2014

Main Takeaways:

1. VA had shorter wait times than the PS in 33.3% of the metropolitan markets across the four analyzed specialties.
2. There was no statistically significant difference between PS and VA wait times for three of the four specialties: cardiology, primary care, and dermatology. VA facilities have statistically significant longer wait times for orthopedics.
3. The difference between average wait times was comparable for SNR and the overall results between regions for all four specialties.

For the year 2014, Merritt-Hawkins published wait time data for the 15 major metropolitan markets. VA had data for all four specialties from facilities in all 15 markets. Overall, VA had shorter wait times than PS in 5 of the 15 metropolitan areas (33.3%) across the four analyzed specialties: Boston, Minneapolis, New York, San Diego, and Washington, DC (Figure 3).

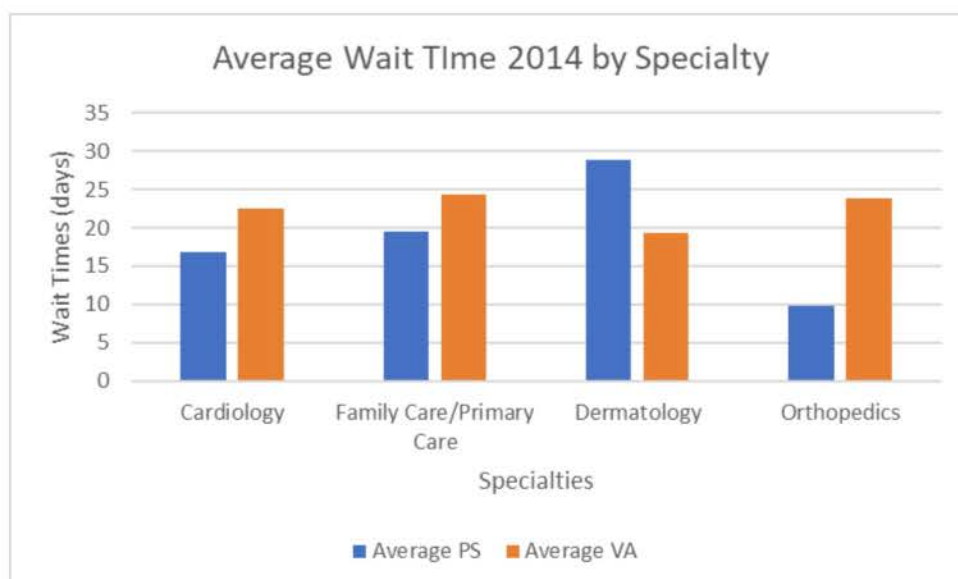
Figure 3:



For three of the four specialties, cardiology, primary care, and dermatology, there was no statistically significant difference between PS and VA wait times (Figure 4). For cardiology, the difference in the average wait time between the PS and VA facilities is 5.7 days, 16.8 days (PS) and 22.5 days (VA), with $p > 0.10$. For primary care, the difference in the average wait time between the PS and VA facilities was 4.8 days, 19.5 days (PS) and 24.3 days (VA), with $p > 0.10$. For dermatology, the difference in the average wait time between PS and VA facilities was 9.5 days, 28.8 days (PS) and 19.3 days (VA), with $p > 0.10$.

VA facilities have statistically significant longer wait times than the private sector for orthopedics. The difference in the average wait time between the private sector and VA facilities was 14.0 days, 9.9 days (PS) and 23.9 days (VA), with $p < 0.05$ and with $F = 8.09 > F_{crit} = 4.03$. Only Boston (6.67% of the 15 metropolitan markets) had a shorter wait time in VA than PS.

Figure 4:



Lastly, the difference between wait times for SNR was comparable to the overall results for all four specialties. There was no statistical significant difference in wait times between PS and VA in the specialties cardiology, primary care, and dermatology in SNRs, with $p > 0.10$. For orthopedics, the difference in the average wait time between the private sector and VA facilities was 13.7 days, 10.5 days (PS) and 24.2 days (VA), with $p < 0.05$.

Table 3:

% Medicaid Acceptance 2014				
City	Cardiology	Primary Care	Dermatology	Orthopedics
Atlanta	90	40	15	20
Boston	85	65	55	70
Dallas	30	30	0	25
Denver	50	20	30	45
Detroit	83	50	45	72
Houston	65	55	40	78
Los Angeles	44	53	7	35
Miami	71	56	45	60
Minneapolis	7	35	15	17
New York	70	32	30	40
Philadelphia	47	67	15	50
Portland	88	60	45	53
San Diego	55	86	10	15
Seattle	70	55	35	28
Wash. DC	63	71	15	44

Tables 4:

Wait Times for PS and VA 2014

City	Cardiology		Primary Care		Dermatology		Orthopedics	
	PS	VA	PS	VA	PS	VA	PS	VA
Atlanta	11	39	24	41	14	2	6	33
Boston	27	25	66	25	72	16	16	9
Dallas	11	19	5	23	17	25	8	15
Denver	28	40	16	27	37	10	15	27
Detroit	17	23	16	16	22	32	18	32
Houston	11	13	19	19	21	19	5	12
Los Angeles	12	8	20	19	14	15	7	19
Miami	18	16	12	26	16	21	9	26
Minneapolis	15	7	10	18	56	27	5	29
New York	15	11	26	14	24	11	9	20
Philadelphia	6	37	21	28	49	12	5	36
Portland	12	25	13	55	27	59	10	30
San Diego	28	17	7	14	14	11	18	18
Seattle	9	39	23	19	32	23	6	30
Wash. DC	32	18	14	19	17	8	11	21

Improvement from 2014 to 2017 for PS and VA*Main Takeaways:*

1. PS wait times improved in 20% of the metropolitan markets across the four analyzed specialties. VA wait times improved in 73.3% of the metropolitan markets across the four analyzed specialties.
2. For PS, there was no statistically significant differences between average wait times between 2014 and 2017, with $p > 0.10$. VA has statistically significant shorter average wait times in 2017 than 2014, with $p < 0.05$
3. For cardiology, primary care, and dermatology, the comparison between PS and VA average wait times moved from statistically insignificant in 2014 to the VA having statistically shorter average wait times across the regions in 2017. For orthopedics, though VA has statistically significant longer average wait times across the regions in both 2014 and 2017, VA has statistically significant shorter average wait times in 2017 than in 2014. The difference in wait times between PS and VA reduced by greater than 50%, from 14.0 days in 2014 to 6.9 days in 2017.

Overall, PS had shorter wait times in 2017 than 2014 in 3 of the 15 metropolitan areas (20%) across the four specialties: Minneapolis, New York, and Washington, DC. In these 3 regions, PS wait times improved by 2 days on average (Figure 5). VA had shorter wait times in 2017 than 2014 in 11 of the 15 metropolitan areas (73.3%) across the four specialties: Atlanta, Boston, Dallas, Denver, Detroit, Houston, Los Angeles, Miami, Portland, San Diego, and Seattle. In these 11 regions, VA wait times

improved by 8 days on average (Figure 6). Though across all major regions the PS wait times worsened by 6 days on average from 2014 to 2017, this wait time increase was not statistically significant, with $p>0.10$. For the VA, across all major regions, wait times improved by 6 days on average from 2014 to 2017, from 22.5 days (2014) to 16.9 days (2017), with $p<0.05$ and with $F=5.90>F_{crit}=4.20$ (Figure 7).

Figure 5:



Figure 6:

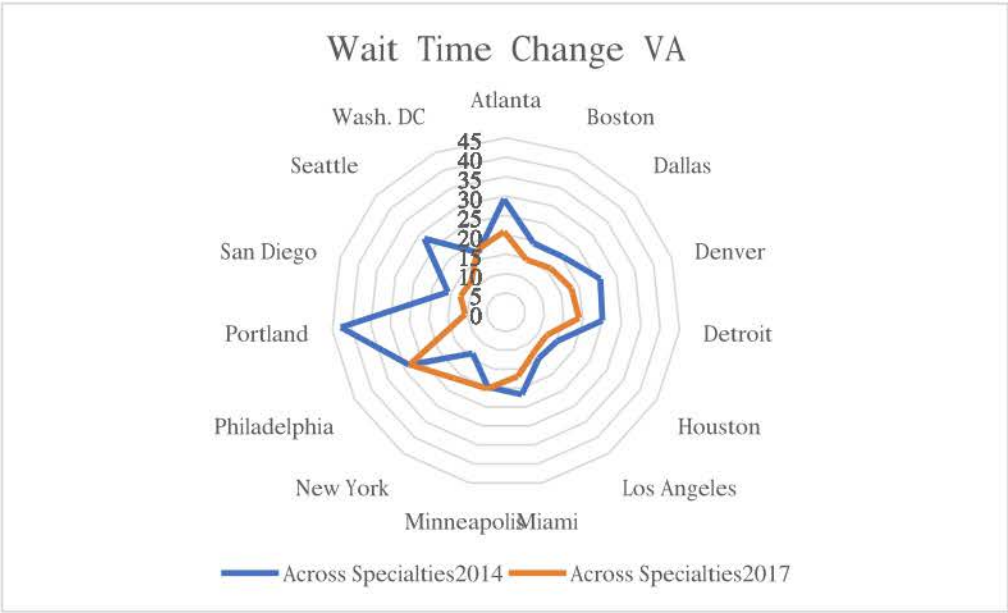
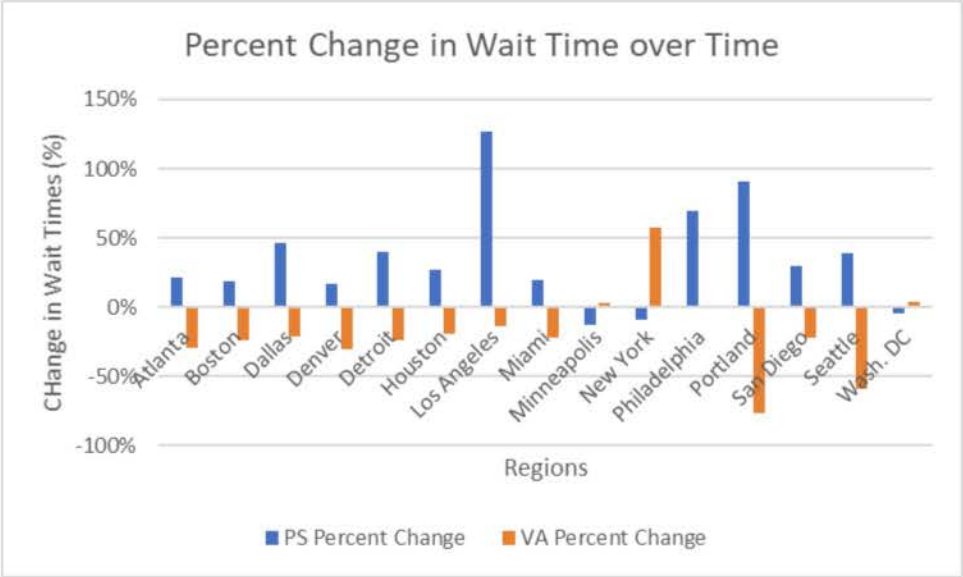


Figure 7:



Within the three specialties cardiology, primary care, and dermatology, the difference in average wait times across the major regions moved from statistically insignificant difference ($p>0.10$) to statistically significant difference ($p<0.05$) from 2014 to 2017. In orthopedics, VA had statistically significant longer average wait time than PS for both 2014 and 2017, with $p<0.05$. However, the difference in the average number of days decreased by more than half from 2014 to 2017, from 14.0 days in 2014 to 6.9 days in 2017. PS has statistically significant longer average wait times in 2017 than 2014 for orthopedics. The difference in the average wait time between 2014 and 2017 was 5.1 days, 9.9 days (2014) and 15.0 days (2017), with $p<0.05$. VA facilities have statistically significant shorter wait times in 2017 than 2014 for orthopedics. The difference in the average wait time between 2014 and 2017 was 5.4 days, 23.9 days (2014) and 18.5 days (2017), with $p<0.05$. This combination of the PS average wait time increasing and VA average wait time improving is closing the gap between wait times for orthopedics in PS and VA facilities, and decreased the difference in average wait times between PS and VA by more than 50% from 2014 to 2017.

Table 5:

Private Sector Wait Times 2014 to 2017

	Cardiology		Primary Care		Dermatology		Orthopedics		Across Specialties	
City	2014	2017	2014	2017	2014	2017	2014	2017	2014	2017
Atlanta	11	16	24	27	14	13	6	11	14	17
Boston	27	45	66	109	72	52	16	8	45	54
Dallas	11	12	5	12	17	22	8	14	10	15
Denver	28	22	16	27	37	51	15	12	24	28
Detroit	17	14	16	27	22	27	18	34	18	26
Houston	11	12	19	21	21	28	5	10	14	18
Los Angeles	12	20	20	42	14	35	7	23	13	30
Miami	18	14	12	28	16	11	9	13	14	17
Minneapolis	15	22	10	8	56	30	5	15	22	19
New York	15	15	26	26	24	15	9	11	19	17
Philadelphia	6	28	21	17	49	78	5	14	20	34
Portland	12	32	13	39	27	30	10	17	16	30
San Diego	28	30	7	13	14	30	18	14	17	22
Seattle	9	16	23	26	32	42	6	13	18	24
Wash. DC	32	18	14	17	17	20	11	16	19	18

Table 6:

VA Wait Times 2014 to 2017

	Cardiology		Primary Care		Dermatology		Orthopedics		Across Specialties	
City	2014	2017	2014	2017	2014	2017	2014	2017	2014	2017
Atlanta	39	42	41	18	2	3	33	19	29	20
Boston	25	0	25	27	16	11	9	19	19	14
Dallas	19	11	23	16	25	27	15	11	21	16
Denver	40	14	27	19	10	7	27	33	26	18
Detroit	23	17	16	13	32	32	32	16	26	20
Houston	13	14	19	12	19	11	12	14	16	13
Los Angeles	8	2	19	9.5	15	23	19	19	15	13
Miami	16	0	26	44	21	9	26	17	22	17
Minneapolis	7	15	18	13	27	37	29	18	20	21
New York	11	11	14	39	11	12	20	25	14	22
Philadelphia	37	59	28	26	12	9	36	19	28	28
Portland	25	6	55	13	59	8	30	13	42	10
San Diego	17	3	14	8	11	20	18	16	15	12
Seattle	39	5	19	13	23	16	30	11	28	11
Wash. DC	18	10	19	27	8	4	21	27	16	17

Discussion:

Overall, VA wait times have historically been similar to those in the PS and has been on a trajectory toward further improvement (while the PS has displayed negligible change to date). Today, VA wait times are on average shorter than the PS. In 2014 during the initiation of the VA wait time crisis, the VA had comparable wait times both across the majority of regions and specialties. Moreover, currently, VA has shorter wait times than PS in 73.3% of the metropolitan markets across the four analyzed specialties and statistically significant shorter wait times in most specialties across regions. VA has taken active efforts to decrease wait times in VA facilities, and this study helps to highlight that over the last three

years VA has been effectively able to greatly improve access across regions and specialties, especially in a time when PS wait times were not changing (if not worsening).

Outpatient access is a critical issue since prior research has evaluated the association between wait times for a first appointment and outcomes of patients and has supported that delayed access to healthcare is related to poorer health, especially among elderly and vulnerable populations.² Much of this research has used VA facilities to examine wait times, because VA is the only health care system to publish wait times. To see a VA doctor, veterans on average have to wait five days for a primary care physician, nine days for a VA specialist, and four days for a mental health professional.³ Additionally, Congress commissioned the Veterans Choice Act Independent Assessment that analyzed VA wait times and provided recommendation on how to improve them.⁴ To our knowledge, Merritt-Hawkins is the first company to publish comprehensive private sector data that can be compared to VA data. The Merritt-Hawkins study comprehensively collected private sector data, but lacked the statistical rigor expressed in this report. They report that new patient PS physician appointment wait times in the 15 major metropolitan areas has increased by 30% since 2014, but neglect to analyze or mention the statistical insignificance considering the variability in wait times across these 15 regions. Our research is a unique study not only because of the statistical rigor it adds to private sector wait time increases, but also because our analysis is the first to comprehensively compare VA wait times to PS wait times.

In the 2017 data, VA had shorter wait times than PS in 73.3% of the metropolitan markets across the four analyzed specialties and statistically significant shorter wait times for three of the four analyzed specialties: cardiology, primary care, and dermatology. However, VA facilities have statistically significant longer wait times for orthopedics. In 2014, VA had shorter wait times than the PS in 33.3% of the metropolitan markets across the four analyzed specialties. VA facilities also had statistically significant longer wait times for orthopedics. There was no statistically significant difference between PS and VA wait times for the other three specialties: cardiology, primary care, and dermatology.

PS wait times improved in few of the metropolitan markets across the four analyzed specialties, while VA wait times improved in most of the metropolitan markets across the four analyzed specialties. For PS, there was no statistically significant differences between average wait times between 2014 and 2017, with $p > 0.10$. VA has statistically significant shorter average wait times in 2017 than in 2014, with $p < 0.05$. For cardiology, primary care, and dermatology, the comparison between PS and VA average wait times moved from statistically insignificant in 2014 to the VA having statistically shorter average wait times across the regions in 2017. For orthopedics, VA had statistically significant longer average wait times than the PS across the regions in both 2014 and 2017. Still, VA has statistically significant

shorter average wait times in 2017 than in 2014. The difference in orthopedic wait times between PS and VA reduced by greater than 50%, from 14.0 days in 2014 to 6.9 days in 2017.

This research can be used to improve Veteran trust in and perception of VA health care, and also for future market analysis of solutions through various interventions. VA staff should pursue different initiatives in regions where the VA is significantly underperforming the private sector, such as assigning more medical staff members to trouble areas or redesigning scheduling algorithms to prioritize certain appointments, versus regions where both VA and PS have lengthy wait times that may require more market specific analysis of the problem.

Though comprehensive given the data available, this study has several limitations. First, the methodology for collecting wait times was different between the Merritt-Hawkins' report and VA data, and the Merritt-Hawkins' method may lead to shorter wait times. For the "secret shoppers" method, the research associates at Merritt-Hawkins called physicians asking to be told the first available time for a new patient appointment. This earliest availability was recorded as the wait time. However, VA data reflects actual times that Veterans waited before seeing a provider, thus this wait time may not reflect the earliest available appointment. If a veteran is unavailable or declines the initial available appointment, and asks to be seen at the next earliest availability (or even a month later), this delayed, but scheduled, appointment is the wait time inputted and documented. Additionally, the patient populations are inherently different between the VA and PS. VA patients are all veterans who are covered by the VA budget, while PS patients are either not veterans, Veterans not covered by VA health care, or Veterans opting out of VA health care. The PS patients could be covered by Medicare, Medicaid, a private insurer, or uninsured. Also, we only have access to 30 metropolitan markets. VA is the largest health care system in the nation with almost 2,000 facilities; with this study, we can only analyze facilities in the 30 regions studied by Merritt-Hawkins, without accounting for the rest of the facilities.

Conclusion:

Our study supports the view that VA facilities have shorter wait times than the private sector for primary care, cardiology, and dermatology. In three of the four specialties, VA facilities had statistically significant shorter wait times in the 30 mid-level and large metropolitan regions, and this finding is consistent across the majority of regions studied. Moreover, the study demonstrates that in 2014, VA wait times were equivalent to those of the private sector, with no statistically significant difference in the wait times for most specialties and regions. Lastly, we found that VA outpatient access across the

studied regions have significantly improved over time, while the private sector's wait times have had no significant change over the last three years.

A crucial next step from this paper is the examination of access to mental health services. Mental health was not addressed in this paper since the Merritt-Hawkins study did not include this specialty. Mental health is a major priority for VA, and we would like to have further research into access across PS and VA. Moreover, once this analysis is achieved, it can be utilized to examine methods for expanding availability in order to better serve our veterans. With PTSD affecting hundreds of thousands of veterans,⁵ this type of initiative is an essential area for further exploration.

¹ <https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Pdf/mha2017waittimesurveyPDF.pdf>

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3191224/>

³ https://www.va.gov/HEALTH/docs/DR70_052017_Pending_and_EWL_Biweekly_Desired_Date_Division.pdf

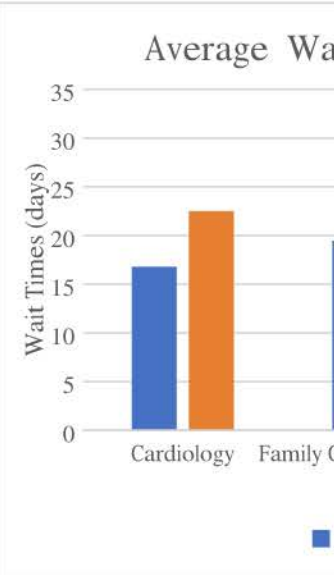
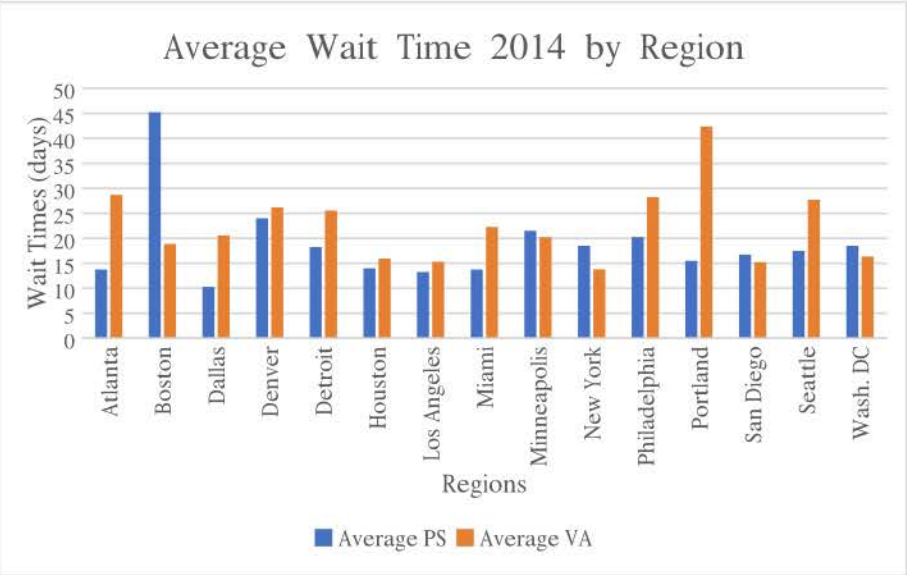
⁴ https://www.va.gov/opa/choiceact/documents/assessments/integrated_report.pdf

⁵ <https://medlineplus.gov/magazine/issues/winter09/articles/winter09pg10-14.html>

Owner: DJS </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: PS_VA_Comparison_wait times_Extended_vf.xlsx
Last Modified: Mon Oct 30 07:40:37 CDT 2017

2014 average wait time by Region

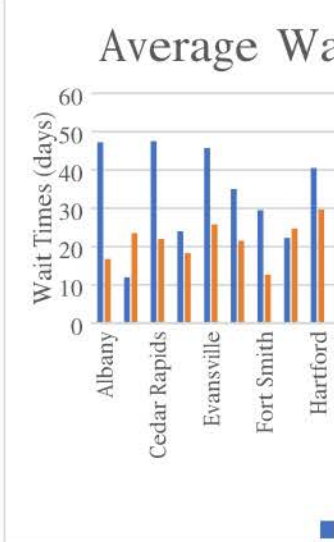
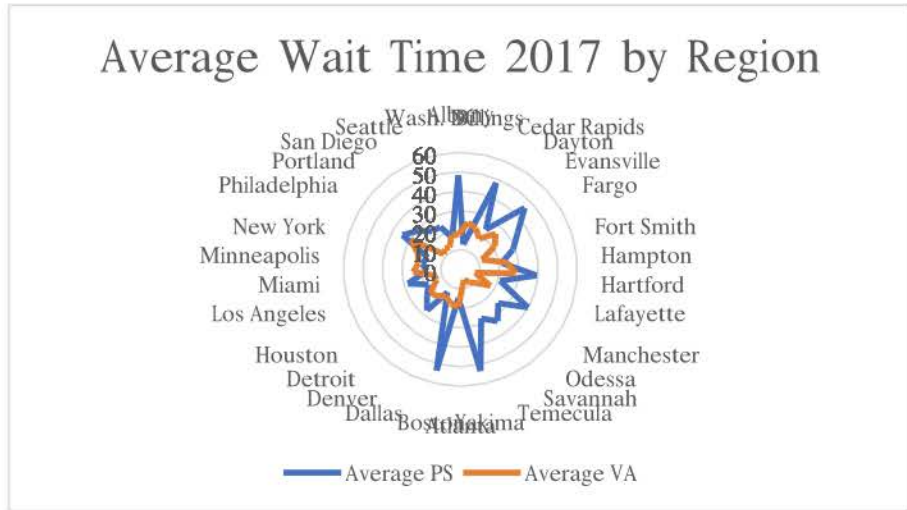
	Atlanta	Boston	Dallas	Denver	Detroit	Houston	Los Angeles	Miami	Minneapolis
Average PS	13.75	45.25	10.25	24	18.25	14	13.25	13.75	21.5
Average VA	28.69326	18.87614	20.59084	26.18547	25.54907	15.93899	15.31139	22.26077	20.22184

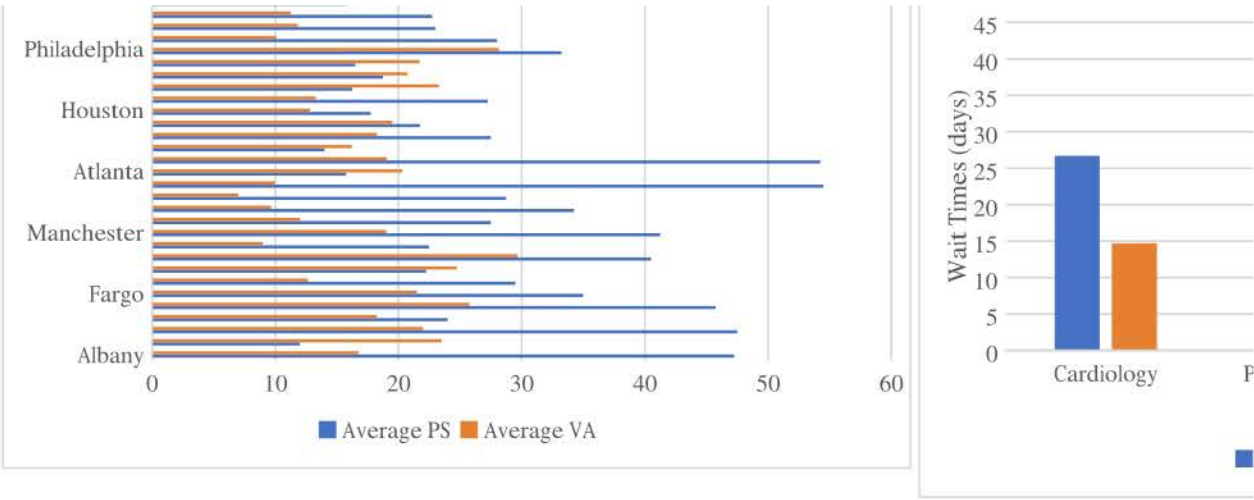


	2014 Cardiology	2014 Family Care	2014 Dermatology	2014 Orthopedics
Average PS	16.8	19.46667	28.8	9.86667
Average VA	22.50092	24.27008	19.30954	23.85298

2017

	Albany	Billings	Cedar Rapids	Dayton	Evansville	Fargo	Fort Smith	Hampton	Hartford
Average PS	47.25	12	47.5	24	45.75	35	29.5	22.25	40.5
Average VA	16.75	23.5	22	18.25	25.75	21.5	12.66667	24.75	29.66667

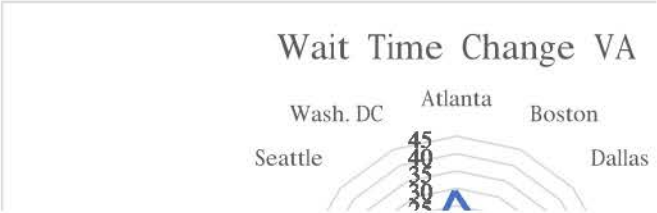




	2017	Cardiology	Primary Ca	Dermatolo	Orthopedics
Average PS	26.7	41.76667	33.66667	13.2	
Average VA	14.69444	20.01724	15.60862	20.93493	

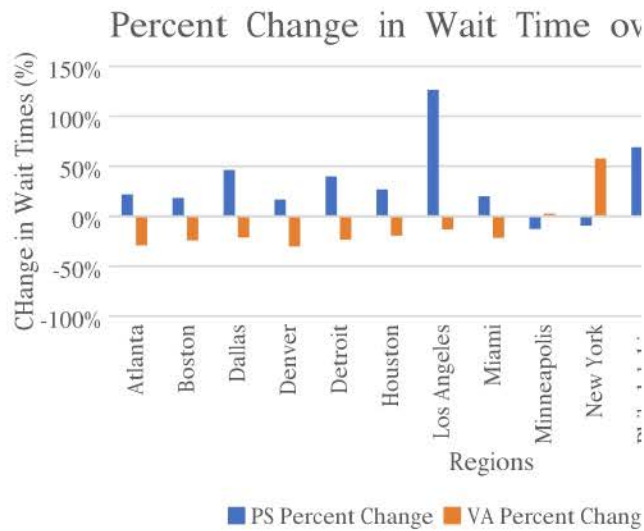
Across Specialties			
City	2014	2017	
Atlanta	13.75	16.75	0.21818
Boston	45.25	53.5	0.18232
Dallas	10.25	15	0.46341
Denver	24	28	0.16667
Detroit	18.25	25.5	0.39726
Houston	14	17.75	0.26786
Los Angeles	13.25	30	1.26415
Miami	13.75	16.5	0.2
Minneapolis	21.5	18.75	-0.12791
New York	18.5	16.75	-0.09459
Philadelphia	20.25	34.25	0.69136
Portland	15.5	29.5	0.90323
San Diego	16.75	21.75	0.29851
Seattle	17.5	24.25	0.38571
Wash. DC	18.5	17.75	-0.04054

Across Specialties			
City	2014	2017	
Atlanta	28.69326	20.31116	-0.29213
Boston	18.87614	14.29968	-0.24245
Dallas	20.59084	16.20131	-0.21318
Denver	26.18547	18.26428	-0.30250
Detroit	25.54907	19.5	-0.23676



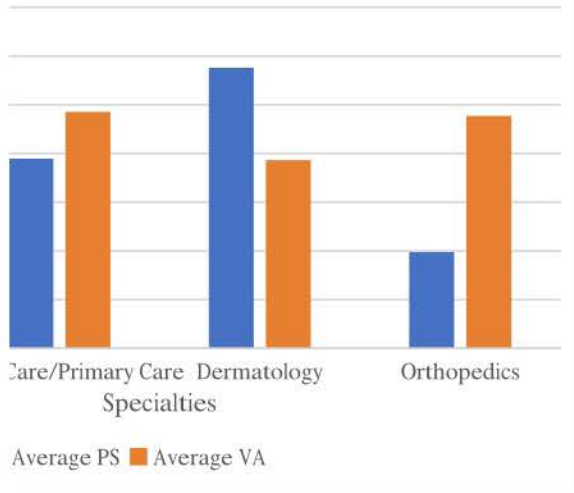
Houston	15.93899	12.82312	-0.19549
Los Angele	15.31139	13.27351	-0.13310
Miami	22.26077	17.45526	-0.21587
Minneapol	20.22184	20.75	0.02612
New York	13.77413	21.73303	0.57782
Philadelph	28.26033	28.13882	-0.00430
Portland	42.34798	10.08089	-0.76195
San Diego	15.20353	11.82805	-0.22202
Seattle	27.70127	11.25	-0.59388
Wash. DC	16.33574	17.01873	0.04181

City	PS Percent	VA Percent	Change
Atlanta	22%	-29%	
Boston	18%	-24%	
Dallas	46%	-21%	
Denver	17%	-30%	
Detroit	40%	-24%	
Houston	27%	-20%	
Los Angeles	126%	-13%	
Miami	20%	-22%	
Minneapolis	-13%	3%	
New York	-9%	58%	
Philadelphia	69%	0%	
Portland	90%	-76%	
San Diego	30%	-22%	
Seattle	39%	-59%	
Wash. DC	-4%	4%	



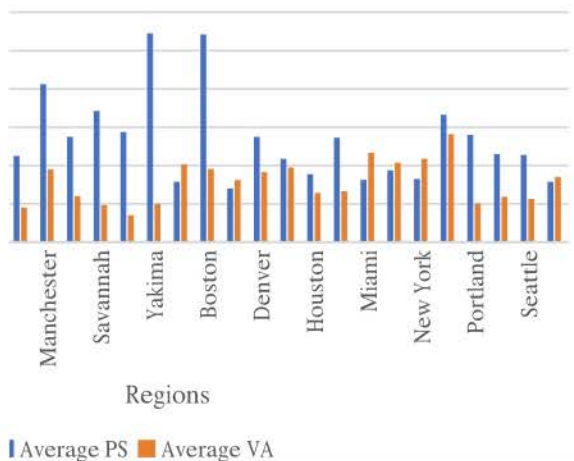
New York	Philadelph	Portland	San Diego	Seattle	Wash. DC
18.5	20.25	15.5	16.75	17.5	18.5
13.77413	28.26033	42.34798	15.20353	27.70127	16.33574

Wait Time 2014 by Specialty

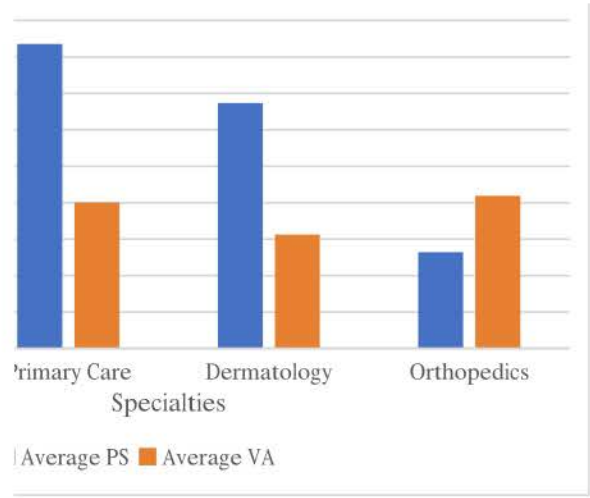


Lafayette	Manchest	Odessa	Savannah	Temecula	Yakima	Atlanta	Boston	Dallas	Denver
22.5	41.25	27.5	34.25	28.75	54.5	15.75	54.25	14	27.5
9	19	12	9.66667	7	10	20.31116	19.06624	16.20131	18.26428

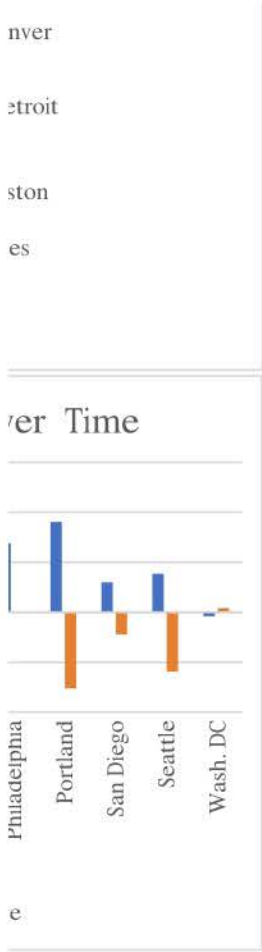
Wait Time 2017 by Region



Wait Time 2017 by Specialty



ector
nver
etroit
ston
es



Detroit	Houston	Los Angeles	Miami	Minneapolis	New York	Philadelphia	Portland	San Diego	Seattle
21.75	17.75	27.25	16.25	18.75	16.5	33.25	28	23	22.75
19.5	12.82312	13.27351	23.27368	20.75	21.73303	28.13882	10.08089	11.82805	11.25

Wash. DC
15.75
17.01873

% Medicaid Acceptance 2014

City	Cardiology	Primary Care	Dermatology	Orthopedics
Atlanta	90	40	15	20
Boston	85	65	55	70
Dallas	30	30	0	25
Denver	50	20	30	45
Detroit	83	50	45	72
Houston	65	55	40	78
Los Angeles	44	53	7	35
Miami	71	56	45	60
Minneapolis	7	35	15	17
New York	70	32	30	40
Philadelphia	47	67	15	50
Portland	88	60	45	53
San Diego	55	86	10	15
Seattle	70	55	35	28
Wash. DC	63	71	15	44

City	Cardiology		Primary Care		Dermatology		Orthopedics
	PS	VA	PS	VA	PS	VA	PS
Atlanta	11	39	24	41	14	2	6
Boston	27	25	66	25	72	16	16
Dallas	11	19	5	23	17	25	8
Denver	28	40	16	27	37	10	15
Detroit	17	23	16	16	22	32	18
Houston	11	13	19	19	21	19	5
Los Angeles	12	8	20	19	14	15	7
Miami	18	16	12	26	16	21	9
Minneapolis	15	7	10	18	56	27	5
New York	15	11	26	14	24	11	9
Philadelphia	6	37	21	28	49	12	5
Portland	12	25	13	55	27	59	10
San Diego	28	17	7	14	14	11	18
Seattle	9	39	23	19	32	23	6
Wash. DC	32	18	14	19	17	8	11

City	Albany	Billings	Cedar Rapids	Dayton	Evansville	Fargo	Fort Smith
Cardiology PS	10	22	10	21	30	39	48
Card VA	5	7	21	20	19	19	19
PC PS	122	7	75	40	76	20	37
PC VA	39	13	23	21	14	19	16
Der PS	46	11	91	23	43	71	10
Der VA	15	7		20	54	29	3
Or PS	11	8	14	12	34	10	23
Or VA	8	67		12	16	19	
Average PS	47	12	48	24	46	35	30

	Cardiology		Family Care/Primary Care		Dermatology		Orthopedics	
City	PS	VA	PS	VA	PS	VA	PS	
Albany		10	5	122	39	46	15	11
Billings		22	7	7	13	11	7	8
Cedar Rapids		10	21	75	23	91		14
Dayton		21	20	40	21	23	20	12
Evansville		30	19	76	14	43	54	34
Fargo		39	19	20	19	71	29	10
Fort Smith		48	19	37	16	10	3	23
Hampton		16	5	35	15	25	28	13
Hartford		40	19	60	48	47	22	15
Lafayette		31	10	10	13	38	4	11
Manchester		46		72		33	15	14
Odessa		63		24	12	6		17
Savannah		36	0	61	23	26	6	14
Temecula		55		22	9	25	4	13
Yakima		18		153	18	31	2	16
Atlanta		16	42	27	18	13	3	7
Boston		45		109	27	52	11	11
Dallas		12	11	12	16	22	27	10
Denver		22	14	27	19	51	7	10
Detroit		14	17	27	13	27	32	19
Houston		12	14	21	12	28	11	10
Los Angeles		20	2	42	10	35	23	12
Miami		14		28	44	11	9	12
Minneapolis		22	15	8	13	30	37	15
New York		15	11	26	39	15	12	10
Philadelphia		28	59	17	26	78	9	10
Portland		32	6	39	13	30	8	11
San Diego		30	3	13	8	30	20	19
Seattle		16	5	26	13	42	16	7
Wash. DC		18	10	17	27	20	4	8

% Medicaid Acceptance 2017

City	Cardiology	Primary Care	Dermatology	Orthopedics
Albany	86	90	20	30
Billings	67	100	40	67
Cedar Rapids	100	33	67	60
Dayton	80	100	20	50
Evansville	100	50	20	100
Fargo	100	100	100	100
Fort Smith	80	56	33	100
Hampton	60	40	20	57

Hartford	90	60	80	50
Lafayette	13	20	0	14
Manchester	60	90	67	50
Odessa	20	50	0	0
Savannah	57	50	25	33
Temecula	70	40	60	71
Yakima	100	80	67	50
Atlanta	85	35	15	25
Boston	100	78	70	75
Dallas	15	25	10	20
Denver	83	20	35	35
Detroit	100	71	25	45
Houston	65	30	10	45
Los Angeles	67	45	30	15
Miami	80	40	25	15
Minneapolis	100	100	85	100
New York	50	80	25	20
Philadelphia	94	88	40	81
Portland	100	55	60	55
San Diego	47	33	50	59
Seattle	77	71	10	55
Wash. DC	94	53	10	10

Orthopedics

VA

33
9
15
27
32
12
19
26
29
20
36
30
18
30
21



Hampton	Hartford	Lafayette	Manchest	Odessa	Savannah	Temecula	Yakima	Atlanta	Boston
16	40	31	46	63	36	55	18	16	45
5	19	10			0			42	
35	60	10	72	24	61	22	153	27	109
15	48	13		12	23	9	18	18	27
25	47	38	33	6	26	25	31	13	52
28	22	4	15		6	4	2	3	11
13	15	11	14	17	14	13	16	7	11
51			23			8		19	19
22	41	23	41	28	34	29	55	16	54

Orthopedics

VA

8

67

12

16

19

51

23

8

19

19

11

33

16

14

19

17

18

25

19

13

16

11

27

Dallas	Denver	Detroit	Houston	Los Angeles	Miami	Minneapolis	New York	Philadelphia	Portland
12	22	14	12	20	14	22	15	28	32
11	14	17	14	2		15	11	59	6
12	27	27	21	42	28	8	26	17	39
16	19	13	12	10	44	13	39	26	13
22	51	27	28	35	11	30	15	78	30
27	7	32	11	23	9	37	12	9	8
10	10	19	10	12	12	15	10	10	11
11	33	16	14	19	17	18	25	19	13
14	28	22	18	27	16	19	17	33	28

San Diego	Seattle	Wash. DC
30	16	18
3	5	10
13	26	17
8	13	27
30	42	20
20	16	4
19	7	8
16	11	27
23	23	16

2014

Cardiology

Family Care/Primary Care Dermatolog

City	VA Facility Name	MSA Size	%medicaid	PS	VA	%medicaid	PS	VA	%medicaid
Atlanta	(2V07) (508) Atlanta	Large	90	11	38.96510	40	24	40.90128	15
Boston	(1V01) (523) Jamaica Plain	Large	85	27	24.9	65	66	25.1	55
Dallas	(4V17) (549) Dallas	Large	30	11	19.25105	30	5	22.85004	0
Denver	(4V19) (554) Denver	Large	50	28	40.14557	20	16	27.27366	30
Detroit	(3V10) (553) Detroit	Large	83	17	22.76257	50	16	15.89724	45
Houston	(4V16) (580) Houston	Large	65	11	13.28888	55	19	19.34937	40
Los Angeles	Average of seven	Large	44	12	8.33053	53	20	19.28329	7
Miami	(2V08) (546) Miami	Large	71	18	16.17989	56	12	25.79942	45
Minneapolis	(3V23) (618) Minneapolis	Large	7	15	6.73936	35	10	18.29322	15
New York	Average of seven	Large	70	15	11	32	26	14.05804	30
Philadelphia	(1V04) (642) Philadelphia	Large	47	6	37.06575	67	21	27.78361	15
Portland	(5V20) (648) Portland	Large	88	12	24.93992	60	13	55.41532	45
San Diego	(5V22) (664) San Diego	Large	55	28	17.10841	86	7	13.98421	10
Seattle	(5V20) (663) Seattle	Large	70	9	38.85714	55	23	18.95538	35
Wash. DC	(1V05) (688) Washington	Large	63	32	18.03420	71	14	19.06251	15

MSA Averages									
Atlanta	(2V07) (508) Atlanta, GA				38.96510			47.46576	
	(2V07) (508GA) Fort McPherson, GA							41.91522	
	(2V07) (508GE) Oakwood, GA							28.55357	
	(2V07) (508GF) Austell, GA							52.22409	
	(2V07) (508GG) Stockbridge, GA							39.60802	
	(2V07) (508GH) Lawrenceville, GA							47.93795	
	(2V07) (508GI) Newnan, GA							31.89847	
	(2V07) (508GJ) Blairsville, GA							39.82745	
	(2V07) (508GK) Carrollton, GA (Trinka Davis Village)							38.68100	
	Average				39.0			40.9	
Boston	(1V01) (523) Jamaica Plain, MA				16.80952			29.89668	
	(1V01) (523A4) West Roxbury, MA				21.12264			13.45853	
	(1V01) (523A5) Brockton, MA				36.84034			21.60992	
	(1V01) (523BY) Lowell, MA							20.22684	
	(1V01) (523BZ) Causeway, MA							11.21543	
	(1V01) (523GA) Framingham, MA							15.62069	
	(1V01) (523GC) Quincy, MA							18.81046	
	(1V01) (523GD) Plymouth, MA							70.31878	
	Average				24.9			25.1	
Dallas	(4V17) (549) Dallas, TX				21.25820			23.80164	
	(4V17) (549A4) Bonham, TX (Sam Rayburn Center)							17.15851	
	(4V17) (549BY) Fort Worth, TX				17.24390			24.68641	
	(4V17) (549GA) Tyler, TX							21.58944	
	(4V17) (549GD) Denton, TX							17.50078	
	(4V17) (549GE) Bridgeport, TX							17.95597	
	(4V17) (549GF) Granbury, TX							48.53304	

	(4V17) (549GH) Greenville, TX				14.21598
	(4V17) (549GJ) Sherman, TX				20.20857
	Average			19.25105	22.85004
Denver	(4V19) (554) Denver, CO			22.33014	19.18754
	(4V19) (554GB) Aurora, CO				24.48532
	(4V19) (554GC) Golden, CO				25.83791
	(4V19) (554GD) Pueblo, CO (PFC James Dunn)				39.49670
	(4V19) (554GE) Colorado Springs, CO (PFC Floyd K			57.96099	41.27855
	(4V19) (554GF) Alamosa, CO				33.86667
	(4V19) (554GG) La Junta, CO				21.85393
	(4V19) (554GH) Lamar, CO				25.80769
	(4V19) (554GI) Burlington, CO				13.64865
	Average			40.14557	27.27366
Detroit	(3V10) (553) Detroit, MI (John D. Dingell)			22.76257	9.45910
	(3V10) (553GA) Yale, MI				21.56667
	(3V10) (553GB) Pontiac, MI				16.66594
	Average			22.76257	15.89724
Houston	(4V16) (580) Houston, TX (Michael E. DeBakey)			13.28888	22.49928
	(4V16) (580BY) Beaumont, TX				14.07031
	(4V16) (580BZ) Lufkin, TX (Charles Wilson)				12.77204
	(4V16) (580GC) Galveston, TX				22.46370
	(4V16) (580GD) Conroe, TX				23.46121
	(4V16) (580GE) Katy, TX				17.46340
	(4V16) (580GF) Lake Jackson, TX				13.53995
	(4V16) (580GG) Richmond, TX				18.88889
	(4V16) (580GH) Tomball, TX				28.98556
	Average			13.28888	19.34937
Los Angeles	(5V22) (691) West Los Angeles, CA			14.80675	10.36649
	(5V22) (691A4) Sepulveda, CA			13.98545	19.39974
	(5V22) (691GB) Santa Barbara, CA			5.90323	14.21942
	(5V22) (691GC) Gardena, CA				9.25684
	(5V22) (691GD) Bakersfield, CA			2.84444	10.52096
	(5V22) (691GE) Los Angeles-East Temple, CA				13.23641
	(5V22) (691GF) East Los Angeles, CA				20.84343
	(5V22) (691GG) Antelope Valley, CA				39.77477
	(5V22) (691GK) San Luis Obispo, CA			8.08333	31.636
	(5V22) (691GL) Santa Maria, CA			4.36	26.16090
	(5V22) (691GM) Oxnard, CA				16.70123
	Average			8.33053	19.28329
Miami	(2V08) (546) Miami, FL (Bruce W. Carter)			14.61608	21.19441
	(2V08) (546BZ) Sunrise, FL (William "Bill" Kling)			33.25692	16.50556
	(2V08) (546GB) Key West, FL				17.86243
	(2V08) (546GC) Homestead, FL				55.36727
	(2V08) (546GD) Pembroke Pines, FL			0.66667	26.98299
	(2V08) (546GE) Key Largo, FL				37.86429
	(2V08) (546GF) Hollywood, FL				12.67089
	(2V08) (546GH) Deerfield Beach, FL				17.94755
	Average			16.17989	25.79942

Minneapolis	(3V23) (618) Minneapolis, MN		16.71788		20.71467
	(3V23) (618BY) Twin Ports, WI		14		23.79148
	(3V23) (618GA) St. James, MN		0		18.76202
	(3V23) (618GB) Hibbing, MN		10.5		20.83849
	(3V23) (618GD) Maplewood, MN		0.84615		23.23016
	(3V23) (618GE) Chippewa Valley, WI		1.68421		17.02797
	(3V23) (618GG) Rochester, MN		0.66667		14.82157
	(3V23) (618GH) Hayward, WI		9.5		10.82114
	(3V23) (618GI) Northwest Metro, MN				20.98705
	(3V23) (618GJ) Shakopee, MN				15.93363
	(3V23) (618GK) Albert Lea, MN				14.29730
	Average		6.73936		18.29322
New York	(1V02) (630) Manhattan, NY		8.77684		18.09043
	(1V02) (630A4) Brooklyn, NY		11.53005		18.05549
	(1V02) (630A5) St. Albans, NY		11.4		9.93166
	(1V02) (630GA) Harlem, NY				22.55319
	(1V02) (630GB) Staten Island, NY				8.91026
	(1V02) (630GC) Chapel Street, NY				10.64103
	(1V02) (526) Bronx, NY (James J. Peters)		11.97839		19.15977
	(1V02) (526GA) White Plains, NY				9.59794
	(1V02) (526GB) Yonkers, NY				9.27160
	(1V02) (526GD) Sunnyside-Queens, NY (Thomas P. Noonan Jr.)				14.36905
	Average		10.92132		14.05804
Philadelphia	(1V04) (642) Philadelphia, PA (Corporal Michael J		26.43037		21.02490
	(1V04) (642GA) Burlington County, NJ		19.93548		27.47974
	(1V04) (642GC) Horsham, PA (Victor J. Saracini)		38.85714		23.23039
	(1V04) (642GD) Gloucester County, NJ		63.04		39.39943
	Average		37.06575		27.78361
Portland	(5V20) (648) Portland, OR		24.93992		32.25787
	(5V20) (648A4) Vancouver, WA				60.48255
	(5V20) (648GA) Bend, OR				82.10455
	(5V20) (648GB) Salem, OR				96.07340
	(5V20) (648GD) North Coast, OR				57.02381
	(5V20) (648GE) Fairview, OR				32.16864
	(5V20) (648GF) Hillsboro, OR				47.42969
	(5V20) (648GG) West Linn, OR				35.78202
	Average		24.93992		55.41532
San Diego	(5V22) (664) San Diego, CA		17.10841		22.36580
	(5V22) (664BY) Mission Valley, CA				13.90552
	(5V22) (664GA) Imperial Valley, CA				15.52174
	(5V22) (664GB) Oceanside, CA				9.39220
	(5V22) (664GC) Chula Vista, CA				8.53633
	(5V22) (664GD) Escondido, CA				14.18365
	Average		17.10841		13.98421
Seattle	(5V20) (663) Seattle, WA		15.64371		18.95538
	Average		15.64371		18.95538
Wash. DC	(1V05) (688) Washington-DC, DC		17.49149		18.88046
	(1V05) (688GA) Fort Belvoir, VA				26.06049

(1V05) (688GB) Southeast Washington, DC				8.93056	
(1V05) (688GC) Greenbelt, MD				16.01893	
(1V05) (688GD) Charlotte Hall, MD	22.11111			15.11773	
(1V05) (688GE) Southern Prince Georges County-	14.5			29.36688	
Average	18.03420			19.06251	

Dermatology**Orthopedics**

PS	VA	%medicaid	PS	VA
14	2	20	6	33
72	16	70	16	9
17	25	25	8	15
37	10	45	15	27
22	32	72	18	32
21	19	78	5	12
14	15	35	7	19
16	21	60	9	26
56	27	17	5	29
24	11	40	9	20
49	12	50	5	36
27	59	53	10	30
14	11	15	18	18
32	23	28	6	30
17	8	44	11	21

	9.47106			32.80672
	0.82456			
	0.63836			
	0.00311			
	0.63763			
	0.23256			
	1.96059			
	2.59302			
	2.53846			
	2.1			32.8
	38.89066			12.10044
	49.17908			
	3.5375			
	1.61765			
	1.45313			
	3.63514			6
	16.4			9.1
	41.37081			21.77623
	33.23401			
	0			9.01174

	24.86827		15.39398
	26.43514		15.82357
	31.33824		
	1.08046		
	2.564		38
	4.28571		
	1.91667		
	14.66667		
	1		
	10.41086		26.91179
	31.80596		31.73051
	31.80596		31.73051
	18.91334		14.59423
			8.71944
			19.78537
			17.46345
			3.65714
			9.00658
	18.91334		12.20437
	11.28755		20.67931
	17.67925		
	0.29730		
	33.60569		17.4
	0		
	24.68259		
	14.59206		19.03966
	33.57891		24.03674
	64.57433		28.16955
	0.88889		
	25.04762		
	1.17391		
	0.5		
	20.96061		26.10314

	26.61188			29.24288
	26.61188			29.24288
	17.21713			17.51232
	10.16655			16.62415
	7.87097			
	5.30769			
	22.90216			24.48278
	0			
	10.57742			19.53975
	37.85281			36.44766
	2			
	6.22222			
	0.90210			
	11.74428			36.44766
	59.57796			16.63241
	58.93064			54.58025
				18.13446
	59.25430			29.78237
	35.22303			21.57057
	2.97635			21.07243
	1.78947			
	19.83913			12.62200
	5.11392			
	2.85714			
	11.29984			18.42167
	22.50215			30.49041
	22.50215			30.49041
	17.17905			20.62952
	0.38542			

	5.28571			
	7.61673			20.62952

2014	OB/Gyn PS	VA
City	%medicaid PS	Gyno Comp Wom's Health
Atlanta	20	1547.77568 33.18914
Boston	70.0	46 32.4 10.4
Dallas	25	10 17.15581 18.59884
Denver	45	22 19.83774 42
Detroit	72	16 50.87692 18.11551
Houston	78	14 28.25536 12.96765
Los Angeles	35	8 25.06964 16.17162
Miami	60	13 37.06411
Minneapolis	17	10 10.42641 20.04032
New York	40	10 14 12
Philadelphia	50	22 13.27219 30.47956
Portland	53	35 12.07770 30.93396
San Diego	15	14 7.93325
Seattle	28	10 15.11993 20.71058
Wash. DC	44	15 15.63377 27.37889

MSA Averages		Gyn	C.W.H
Atlanta		47.77568	30.37829
			36
	Average	47.77568	33.18914
Boston	(1V01) (523) Jamaica Plain, MA	24.98361	11.95858
	(1V01) (523A5) Brockton, MA	39.86667	8.86765
	Average	32.42514	10.41311
Dallas	(4V17) (549) Dallas, TX	18.19733	14.45833
	Bonham, TX (Sam Rayburn Center)	16.11429	11.96491
	(4V17) (549BY) Fort Worth, TX		28.57093
	(4V17) (549GD) Denton, TX		19.5
	(4V17) (549GF) Granbury, TX		18.5
	Average	17.15581	18.59884
Denver	(4V19) (554) Denver, CO	18.21021	
	(4V19) (554GC) Golden, CO	45.72727	
	(4V19) (554GD) Pueblo, CO (PFC James Dunn)	8	

	(1V12) (631GB) Colorado Springs, CO (PFC Floyd K. Lindstrom)		7.41346	42
		Average	19.83774	42
Detroit	(3V10) (553) Detroit, MI (John D. Dingell)		50.87692	18.11551
Houston	(4V16) (580) Houston, TX (Michael E. DeBakey)		28.25536	12.96765
Los Angeles	(5V22) (691) West Los Angeles, CA		20.60702	10.65614
	(5V22) (691A4) Sepulveda, CA		29.53226	14.60606
	Santa Barbara, CA			31.25
	(5V22) (691GD) Bakersfield, CA			10.11111
	(5V22) (691GE) Los Angeles-East Temple, CA			15.56667
	(5V22) (691GL) Santa Maria, CA			21.63636
	(5V22) (691GM) Oxnard, CA			9.375
		Average	25.06964	16.17162
Miami	(2V08) (546) Miami, FL (Bruce W. Carter)		35.21959	
	(2V08) (546BZ) Sunrise, FL (William "Bill" Kling)		38.90863	
		Average	37.06411	
Minneapolis	(3V23) (618) Minneapolis, MN		17.63203	20.04032
	(3V23) (618BY) Twin Ports, WI		11.5	
	(3V23) (618GB) Hibbing, MN		13	
	(3V23) (618GE) Chippewa Valley, WI		10	
	(3V23) (618GH) Hayward, WI		0	
		Average	10.42641	20.04032
New York	(1V02) (630) Manhattan, NY		12.43	24.05
	(1V02) (630A4) Brooklyn, NY		13.18156	10.90625
	(1V02) (630A5) St. Albans, NY			1.5
	(1V02) (526) Bronx, NY (James J. Peters)		16.84739	
		Average	14.15298	12.15208

Philadelphia	(1V04) (642) Philadelphia, PA (Corporal Michael J. Crescenz)		13.27219	32.06699
	(1V04) (642GA) Burlington County, NJ			30.4
	(1V04) (642GB) Horsham, PA (Victor J. Saracini)			43.53191
	(1V04) (642GD) Gloucester County, NJ			15.91935
		Average	13.27219	30.47956
Portland	(5V20) (648) Portland, OR		12.07770	30.93396
San Diego	(5V22) (664) San Diego, CA		6.22559	
	(5V22) (664BY) Mission Valley, CA		10.28846	
	(5V22) (664GB) Oceanside, CA		7.28571	
		Average	7.93325	
	(5V20) (663) Seattle, WA		11.48031	10.67073
Seattle	(5V20) (663A4) American Lake, WA		18.75954	30.75042
		Average	15.11993	20.71058
	(1V05) (688) Washington-DC, DC		15.63377	21.75778
	(1V05) (688GC) Greenbelt, MD			33
		Average	15.63377	27.37889

Anova: Single Factor

Just GYN.

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	260	17.33333	109.52381
Column 2	15	347.07663	23.13844	181.92961

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	252.74466	1	252.74466	1.73437	0.19853	4.19597
Within Groups	80.34794	28	145.72671			
Total	333.09260	29				

Anova: Single Factor

Gyn+CWH

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	260	17.33333	109.52381
Column 2	15	342.61264	22.84084	82.42248

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	227.49492	1	227.49492	2.37040	0.13488	4.19597
Within Groups	687.24812	28	95.97315			
Total	914.74304	29				

2017

Cardiology

City	VA Facility Name	MSA Size	%medicaid	PS
Albany	(1V02) (528A8) Albany, NY (Samuel S. Stratton)	Mid-sized	86	10
Billings	(4V19) (436GH) Billings, MT	Mid-sized	67	22
Cedar Rapids	(3V23) (636GN) Cedar Rapids, IA	Mid-sized	100	10
Dayton	(3V10) (552) Dayton, OH	Mid-sized	80	21
Evansville	(3V15) (657GJ) Evansville, IN	Mid-sized	100	30
Fargo	(3V23) (437) Fargo, ND	Mid-sized	100	39
Fort Smith	(4V16) (564GB) Fort Smith, AR	Mid-sized	80	48
Hampton	(1V06) (590) Hampton, VA	Mid-sized	60	16
Hartford	(1V01) (689A4) Newington, CT	Mid-sized	90	40
Lafayette	(4V16) (502GB) Lafayette, LA	Mid-sized	13	31
Manchester	(1V01) (608) Manchester, NH	Mid-sized	60	46
Odessa	(4V17) (519GA) Permian Basin, TX	Mid-sized	20	63
Savannah	(2V07) (534BY) Savannah, GA	Mid-sized	57	36
Temecula	(5V22) (605GB) Murrieta, CA	Mid-sized	70	55
Yakima	(5V20) (687HA) Yakima, WA	Mid-sized	100	18
Atlanta	(2V07) (508) Atlanta, GA	Large	85	16
Boston	(1V01) (523) Jamaica Plain, MA	Large	100	45
Dallas	(4V17) (549) Dallas, TX	Large	15	12
Denver	(4V19) (554) Denver, CO	Large	83	22
Detroit	(3V10) (553) Detroit, MI (John D. Dingell)	Large	100	14
Houston	(4V16) (580) Houston, TX (Michael E. DeBakey)	Large	65	12
Los Angeles	Average of several facilities	Large	67	20
Miami	(2V08) (546) Miami, FL (Bruce W. Carter)	Large	80	14
Minneapolis	(3V23) (618) Minneapolis, MN	Large	100	22
New York	(1V02) (630) New York HCS	Large	50	15
Philadelphia	(1V04) (642) Philadelphia, PA (Corporal Michael J. Crescenzo)	Large	94	28
Portland	(5V20) (648) Portland, OR	Large	100	32
San Diego	(5V22) (664) San Diego, CA	Large	47	30
Seattle	(5V20) (663) Seattle, WA	Large	77	16
Wash. DC	(1V05) (688) Washington-DC, DC	Large	94	18

MSA Averages				
Albany	(1V02) (528A8) Albany, NY (Samuel S. Stratton)			
	(1V02) (528GT) Glens Falls, NY			
	(1V02) (528GV) Plattsburgh, NY			
	(1V02) (528GW) Schenectady, NY			
	(1V02) (528GX) Troy, NY			
	(1V02) (528GY) Clifton Park, NY			
	(1V02) (528GZ) Kingston, NY			
	Average			
Fargo	(3V23) (437) Fargo, ND			
	(3V23) (437GD) Minot, ND			
	(3V23) (437GI) Grand Forks, ND			
	(3V23) (437GA) Grafton, ND			

	(3V23) (437GC) Fergus Falls, MN			
	(3V23) (437GE) Bemidji, MN			
	Average			
Atlanta	(2V07) (508GA) Fort McPherson, GA			
	(2V07) (508GE) Oakwood, GA			
	(2V07) (508GF) Austell, GA			
	(2V07) (508GG) Stockbridge, GA			
	(2V07) (508GH) Lawrenceville, GA			
	(2V07) (508GI) Newnan, GA			
	(2V07) (508GJ) Blairsville, GA			
	(2V07) (508GK) Carrollton, GA (Trinka Davis Village)			
	(2V07) (508GL) Rome, GA			
	(2V07) (508QF) Atlanta-Arcadia Avenue, GA			
	(2V07) (508) Atlanta, GA			
	(2V07) (508QD) Fulton County, GA			
	Average			
Boston	(1V01) (523) Jamaica Plain, MA			
	(1V01) (523A4) West Roxbury, MA			
	(1V01) (523A5) Brockton, MA			
	(1V01) (523BY) Lowell, MA			
	(1V01) (523GA) Framingham, MA			
	(1V01) (523GD) Plymouth, MA			
	Average			
Dallas	(4V17) (549) Dallas, TX			
	(4V17) (549A4) Bonham, TX (Sam Rayburn Center)			
	(4V17) (549BY) Fort Worth, TX			
	Average			
Denver	(4V19) (554) Denver, CO			
	(4V19) (554GB) Aurora, CO			
	(4V19) (554GC) Golden, CO			
	(4V19) (554GD) Pueblo, CO (PFC James Dunn)			
	(4V19) (554GE) Colorado Springs, CO (PFC Floyd K. Lindstrom)			
	(4V19) (554GF) Alamosa, CO			
	(4V19) (554GG) La Junta, CO			
	(4V19) (554GI) Burlington, CO			
	(4V19) (554QC) Salida, CO			
	Average			
Houston	(4V16) (580) Houston, TX (Michael E. DeBakey)			
	(4V16) (580BZ) Lufkin, TX (Charles Wilson)			
	(4V16) (580GD) Conroe, TX			
	(4V16) (580GE) Katy, TX			
	(4V16) (580GG) Richmond, TX			
	(4V16) (580GH) Tomball, TX			
	Average			
Los Angeles	(5V22) (691) West Los Angeles, CA			
	(5V22) (691A4) Sepulveda, CA			
	(5V22) (691GE) Los Angeles-East Temple, CA			
	(5V22) (691GL) Santa Maria, CA			

	Average			
Miami	(2V08) (546) Miami, FL (Bruce W. Carter)			
	(2V08) (546BZ) Sunrise, FL (William "Bill" Kling)			
	(2V08) (546GB) Key West, FL			
	(2V08) (546GC) Homestead, FL			
	(2V08) (546GE) Key Largo, FL			
	(2V08) (546GF) Hollywood, FL			
	Average			
New York	(1V02) (630) Manhattan, NY			
	(1V02) (630A4) Brooklyn, NY			
	(1V02) (630A5) St. Albans, NY			
	Average			
Philadelphia	(1V04) (642) Philadelphia, PA (Corporal Michael J. Crescenz)			
	(1V04) (642GA) Burlington County, NJ			
	(1V04) (642GC) Horsham, PA (Victor J. Saracini)			
	(1V04) (642GD) Gloucester County, NJ			
	Average			
Portland	(5V20) (648) Portland, OR			
	(5V20) (648A4) Vancouver, WA			
	(5V20) (648GA) Bend, OR			
	(5V20) (648GB) Salem, OR			
	(5V20) (648GE) Fairview, OR			
	(5V20) (648GG) West Linn, OR			
	(5V20) (648GF) Hillsboro, OR			
	Average			
San Diego	(5V22) (664) San Diego, CA			
	(5V22) (664BY) Mission Valley, CA			
	(5V22) (664GB) Oceanside, CA			
	Average			
Wash., DC	(1V05) (688) Washington-DC, DC			
	(1V05) (688GA) Fort Belvoir, VA			
	(1V05) (688GE) Southern Prince Georges County-Andrews Air Force Base, MD			

Cardiology

Family Care/Primary Care

Dermatology

Orthopedics

VA	%medicaid	PS	VA	%medicaid	PS	VA	%medicaid	PS	VA
5	90	122	39	20	46	15	30	11	8
7	100	7	13	40	11	7	67	8	67
21	33	75	23	67	91		60	14	
20	100	40	21	20	23	20	50	12	12
19	50	76	14	20	43	54	100	34	16
19	100	20	19	100	71	29	100	10	19
19	56	37	16	33	10	3	100	23	
5	40	35	15	20	25	28	57	13	51
19	60	60	48	80	47	22	50	15	
10	20	10	13	0	38	4	14	11	
	90	72		67	33	15	50	14	23
	50	24	12	0	6		0	17	
0	50	61	23	25	26	6	33	14	
	40	22	9	60	25	4	71	13	8
	80	153	18	67	31	2	50	16	
42	35	27	18	15	13	3	25	7	19
	78	109	27	70	52	11	75	11	19
11	25	12	16	10	22	27	20	10	11
14	20	27	19	35	51	7	35	10	33
17	71	27	13	25	27	32	45	19	16
14	30	21	12	10	28	11	45	10	14
2	45	42	9.5	30	35	23	15	12	19
	40	28	44	25	11	9	15	12	17
15	100	8	13	85	30	37	100	15	18
11	80	26	39	25	15	12	20	10	25
59	88	17	26	40	78	9	81	10	19
6	55	39	13	60	30	8	55	11	13
3	33	13	8	50	30	20	59	19	16
5	71	26	13	10	42	16	55	7	11
10	53	17	27	10	20	4	10	8	27

					46	42.69565		11	15
					46	0		11	
					46	7		11	
					46	0.28571		11	
					46	0		11	
					46	3.66667		11	
					46	1		11	
					46	7.80686		11	15
					71	81		10	19
					71	6		10	
					71	0		10	
					71			10	

					71			10	
					71			10	
					71	29		10	19
					130.59259			7	
					1.07143				
					0				
					0.42308				
					1.02564				
					0.34615				
					0.78571				
					1.5				22
					1				
					20.42029				
								21.72727	
								11.85714	
					13	2.71649		7	18.52814
					52	17.62703		11	19
					20.50980				
					28.05556				
					0				
					0				
					1				
					52	11.19873		11	19
					22	24.03571		10	14
					24.29670				
					32.08333				8
					22	26.80525		10	11
					51	27.12025		10	33
					0.75				
					21.28				
					1.61111				
					4.21951				33
					2				
					3.2				
					0				
					3.33333				
					51	7.05713		10	33
					28	11		10	11.87059
									14.29412
									24.29630
									3
									12.77778
									19.51613
					28	11		10	14.29248
					35	16.25714		12	19
					36.34286				
					7.50943				
					30.26667				

					35	22.59402		12	19
					11	17.73684		12	16
						22.36842			18
					0				
					4				
					0				
					11	8.82105		12	17
					15	18.49167		10	26.30769
						9.17			24.41176
						8.05556			
					15	11.90574		10	25.35973
					78	23.69620		10	19
						0.33333			
						1.63636			
					78	8.55530		10	19
						17.73653			19
						4.66667			
						1.46667			
						16.42857			
						5.14286			
						4.5			
									7
						8.32355			13
					30	34.72483		19	11.24390
					0				21.43939
						25.24272			16.28571
					30	19.98918		19	16.32300
					20	12.02479		8	27
					0				
					0.2				

|

| |

2017

City	Albany	Billings	Cedar Rapi	Dayton	Evansville	Fargo	Fort Smith	Hampton	Hartford
Cardiology P	10	22	10	21	30	39	48	16	40
Card VA	5	7	21	20	19	19	19	5	19
PC PS	122	7	75	40	76	20	37	35	60
PC VA	39	13	23	21	14	19	16	15	48
Der PS	46	11	91	23	43	71	10	25	47
Der VA	15	7		20	54	29	3	28	22
Or PS	11	8	14	12	34	10	23	13	15
Or VA	8	67		12	16	19		51	
Average PS	47	12	48	24	46	35	30	22	41
Average VA	17	24	22	18	26	22	13	25	30
VA<PS?	31	-12	26	6	20	14	17	-3	11

2014

City	Atlanta	Boston	Dallas	Denver	Detroit	Houston	Los Angele	Miami	Minneapol
Cardiology P	11	27	11	28	17	11	12	18	15
Card VA	38.96510	24.92417	19.25105	40.14557	22.76257	13.28888	8.33053	16.17989	6.73936
PC PS	24	66	5	16	16	19	20	12	10
PC VA	40.90128	25.14466	22.85004	27.27366	15.89724	19.34937	19.28329	25.79942	18.29322
Der PS	14	72	17	37	22	21	14	16	56
Der VA	2.09993	16.38552	24.86827	10.41086	31.80596	18.91334	14.59206	20.96061	26.61188
Or PS	6	16	8	15	18	5	7	9	5
Or VA	32.80672	9.05022	15.39398	26.91179	31.73051	12.20437	19.03966	26.10314	29.24288
Average PS	14	45	10	24	18	14	13	14	22
Average VA	29	19	21	26	26	16	15	22	20
VA<PS?	-15	26	-10	-2	-7	-2	-2	-9	1

Lafayette	Mancheste	Odessa	Savannah	Temecula	Yakima	Atlanta	Boston	Dallas	Denver
31	46	63	36	55	18	16	45	12	22
10			0			42		11	14
10	72	24	61	22	153	27	109	12	27
13		12	23	9	18	18	27	16	19
38	33	6	26	25	31	13	52	22	51
4	15		6	4	2	2.71649	11.19873	26.80525	7.05713
11	14	17	14	13	16	7	11	10	10
	23			8		18.52814	19	11	33
23	41	28	34	29	55	16	54	14	28
9	19	12	10	7	10	20	19	16	18
14	22	16	25	22	45	-5	35	-2	9

New York	Philadelph	Portland	San Diego	Seattle	Wash. DC
15	6	12	28	9	32
10.92132	37.06575	24.93992	17.10841	38.85714	18.03420
26	21	13	7	23	14
14.05804	27.78361	55.41532	13.98421	18.95538	19.06251
24	49	27	14	32	17
10.57742	11.74428	59.25430	11.29984	22.50215	7.61673
9	5	10	18	6	11
19.53975	36.44766	29.78237	18.42167	30.49041	20.62952
19	20	16	17	18	19
14	28	42	15	28	16
5	-8	-27	2	-10	2

Detroit	Houston	Los Angeles	Miami	Minneapolis	New York	Philadelphia	Portland	San Diego	Seattle
14	12	20	14	22	15	28	32	30	16
17	14	2		15	10.66667	59	6	3	5
27	21	42	28	8	26	17	39	13	26
13	12	9.5	44	13	39	26	13	8	13
27	28	35	11	30	15	78	30	30	42
32	11	22.59402	8.82105	37	11.90574	8.55530	8.32355	19.98918	16
19	10	12	12	15	10	10	11	19	7
16	14.29248	19	17	18	25.35973	19	13	16.32300	11
22	18	27	16	19	17	33	28	23	23
20	13	13	23	21	22	28	10	12	11
2	5	14	-7	-2	-5	5	18	11	12

Wash. DC
18
10
17
27
20
4.07493
8
27
16
17
-1

	Cardiology		Primary Care		Dermatology		Orthopedics		Across Specialties
City	2014	2017	2014	2017	2014	2017	2014	2017	2014
Atlanta	11	16	24	27	14	13	6	11	14
Boston	27	45	66	109	72	52	16	8	45
Dallas	11	12	5	12	17	22	8	14	10
Denver	28	22	16	27	37	51	15	12	24
Detroit	17	14	16	27	22	27	18	34	18
Houston	11	12	19	21	21	28	5	10	14
Los Angeles	12	20	20	42	14	35	7	23	13
Miami	18	14	12	28	16	11	9	13	14
Minneapolis	15	22	10	8	56	30	5	15	22
New York	15	15	26	26	24	15	9	11	19
Philadelphia	6	28	21	17	49	78	5	14	20
Portland	12	32	13	39	27	30	10	17	16
San Diego	28	30	7	13	14	30	18	14	17
Seattle	9	16	23	26	32	42	6	13	18
Wash. DC	32	18	14	17	17	20	11	16	19

Across Specialties	
	2017
	17
	54
	15
	28
	26
	18
	30
	17
	19
	17
	34
	30
	22
	24
	18

	Cardiology		Primary Care		Dermatology		Orthopedics	Across Specialties	
City	2014	2017	2014	2017	2014	2017	2014	2017	2014
Atlanta	39	42	41	18	2	3	33	19	29
Boston	25	0	25	27	16	11	9	19	19
Dallas	19	11	23	16	25	27	15	11	21
Denver	40	14	27	19	10	7	27	33	26
Detroit	23	17	16	13	32	32	32	16	26
Houston	13	14	19	12	19	11	12	14	16
Los Angeles	8	2	19	9.5	15	23	19	19	15
Miami	16	0	26	44	21	9	26	17	22
Minneapolis	7	15	18	13	27	37	29	18	20
New York	11	11	14	39	11	12	20	25	14
Philadelphia	37	59	28	26	12	9	36	19	28
Portland	25	6	55	13	59	8	30	13	42
San Diego	17	3	14	8	11	20	18	16	15
Seattle	39	5	19	13	23	16	30	11	28
Wash. DC	18	10	19	27	8	4	21	27	16

Across Specialties	
	2017
	20
	14
	16
	18
	20
	13
	13
	17
	21
	22
	28
	10
	12
	11
	17

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	32	831	25.96875	197.06351
Column 2	25	374	14.96	157.29

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	700.94844	1	700.94844	9.46508	0.00326	4.01620
Within Groups	883.92875	55	179.70780			
Total	584.87719	56				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	30	801	26.7201	1.80345
Column 2	24	352.66667	14.69444	167.89291

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	921.77819		1921.77819	10.28764	0.00229	4.02663
Within Groups	713.83704		52186.80456			
Total	635.61523	53				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	25	650	26	172.5
Column 2	20	318	15.9191	17.7895

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	133.44444	1	133.44444	6.26148	0.01622	4.06705
Within Groups	7783.8	43	181.01860			
Total	917.24444	44				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	36	1425	39.58333074	99286
Column 2	35	785	22.42857155	60504

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	222.53773	1	222.53773	8.39689	0.00503	3.97981
Within Groups	915.32143	69	13.12060044			
Total	1137.85915	70				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	30	1253	41.76667	260.46092
Column 2	29	580.5	20.01724	111.97291

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	975.29873	1	975.29873	10.01779	0.00249	4.00987
Within Groups	688.60805	57	12.07909			
Total	1663.90678	58				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	16	766	47.875	1961.05
Column 2	15	322	21.46667	109.26667

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	399.22634	1	399.22634	5.05979	0.03225	4.18296
Within Groups	945.48333	29	32.60287			
Total	1344.70968	30				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	30	1010	33.66667	403.05747
Column 2	28	437.04138	15.60862	153.45174

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	722.72649	1	722.72649	16.70509	0.00014	4.01297
Within Groups	831.86356	56	14.85471			
Total	554.59005	57				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	9	358	39.77778	720.69444
Column 2	8	90.78571	11.34821	160.05166

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	423.13447	1	423.13447	7.45682	0.01547	4.54308
Within Groups	885.91717	15	59.06114			
Total	1309.05164	16				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	30	396	13.2	29.06207
Column 2	23	481.50335	20.93493	184.81295

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	778.90738	1	778.90738	8.09265	0.00638	4.03039
Within Groups	908.68501	51	17.81735			
Total	687.59239	52				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	13	158	12.15385	79.80769
Column 2	11	209.70425	19.064024	65.74028

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	284.51362	1	284.51362	1.11473	0.30251	4.30095
Within Groups	615.09511	22	27.95887			
Total	899.60874	23				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	281	18.73333	66.51310
Column 2	15	366	24.4	100.75714

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	240.83333	1	240.83333	2.87957	0.10080	4.19597
Within Groups	341.78333	28	12.20690			
Total	582.61667	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	337.25073	22.48338	57.10953
Column 2	15	252.92785	16.86186	23.30139

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	237.01157	1	237.01157	5.89501	0.02186	4.19597
Within Groups	125.75288	28	40.20546			
Total	362.76446	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	252	16.8	65.6
Column 2	15	316	21.06667	84.63810

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	136.53333	1	136.53333	1.81756	0.18841	4.19597
Within Groups	103.33333	28	75.11905			
Total	239.86667	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	349.40171	23.29345	122.87735
Column 2	15	208.66667	13.91111	261.21376

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	660.21175	1	660.21175	3.43779	0.07428	4.19597
Within Groups	377.27543	28	13.47591			
Total	1037.48718	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	292	19.46667	203.55238
Column 2	15	439	29.26667	574.06667

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	720.3	1	720.3	1.85258	0.18434	4.19597
Within Groups	886.66667	28	31.66667			
Total	1606.96667	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	364.05126	24.27008	120.96199
Column 2	15	297.5	19.83333	114.70238

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	147.63565	1	147.63565	1.25293	0.27250	4.19597
Within Groups	299.30117	28	10.70718			
Total	446.93682	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	432	28.8308	8.88571
Column 2	15	484	32.2667	312.35238

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	90.13333	1	90.13333	0.29017	0.59437	4.19597
Within Groups	697.33333	28	24.90476			
Total	787.46667	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	289.64316	19.30954	184.96898
Column 2	15	228.04138	15.20276	106.63943

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	126.49262	1	126.49262	0.86755	0.35960	4.19597
Within Groups	82.51763	28	2.94706			
Total	209.01025	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	148	9.86667	22.26667
Column 2	15	225	15	39.71429

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	197.63333	1	197.63333	6.37723	0.01750	4.19597
Within Groups	867.73333	28	30.99048			
Total	1065.36667	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	357.79465	23.85298	66.54022
Column 2	15	277.50335	18.50022	36.01780

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	214.88972	1	214.88972	4.19060	0.05014	4.19597
Within Groups	435.81225	28	15.56830			
Total	650.70197	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	252	16.8	65.6
Column 2	15	337.51384	22.50092	131.54824

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	243.75392	1	243.75392	2.47280	0.12706	4.19597
Within Groups	760.07532	28	98.57412			
Total	1003.82924	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	292	19.46667	203.55238
Column 2	15	364.05126	24.27008	120.96199

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	173.04611	1	173.04611	1.06649	0.31058	4.19597
Within Groups	543.20117	28	19.40004			
Total	716.24728	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	432	28.8308	8.88571
Column 2	15	289.64316	19.30954	184.96898

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	675.51569	1	675.51569	2.73569	0.10930	4.19597
Within Groups	913.96566	28	32.64163			
Total	589.48135	29				

Anova: Single Factor

SUMMARY

<i>Groups</i>	<i>Count</i>	<i>Sum</i>	<i>Average</i>	<i>Variance</i>
Column 1	15	148	9.86667	22.26667
Column 2	15	357.79465	23.85298	66.54022

ANOVA

<i>Source of Variation</i>	<i>SS</i>	<i>df</i>	<i>MS</i>	<i>F</i>	<i>P-value</i>	<i>F crit</i>
Between Groups	467.12644	1	467.12644	33.04083	0.000004	4.19597
Within Groups	243.29642	28	44.40344			
Total	710.42286	29				

From: (b)(6) /o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn (b)(6) >
To:
Cc:
Bcc:
Subject: Moring Report 5/1/2017
Date: Fri Apr 28 2017 15:43:30 CDT
Attachments: EAS

All,

Attached is the Morning Report for Monday, May 1, 2017. This document is for internal use only.

(b)(6)

Program Analyst, Corporate Enterprise
Office of Congressional and Legislative Affairs
Department of Veterans Affairs
810 Vermont Ave., NW
Desk: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Monday, May 1, 2017

Hot Issues

- None

Emerging

- None

Congressional Letters and Meeting Requests Received

- None

Friday, April 28, 2017 Events

- April 27, 2017. HVAC-Health conducted a Roundtable discussion to examine how VA can improve the Caregiver Support Program. The discussion will consider alternative and existing models of long-term care such as Veterans Directed Home and Community Based Services Program. VA participants: Dr. Lucille Beck, Acting Deputy Under Secretary for Health for Policy and Services; Meg Kabat, Director, Caregiver Support Program; Elyse Kaplan, Deputy Director, Caregiver Support Program; Dr. Richard Allman, Chief Consultant Geriatrics and Extended Care Services (GEC); and Daniel Schoeps, Direct Purchased Long Term Services.

1:00 P.M.; 334 Cannon

POC: (b)(6)

Summary: Of the 12 HVAC-Health Subcommittee members all but 3 (Radewagen, Gonzalez-Colon, and Correa) attended the Roundtable on the Caregiver Support Program (CSP). Other participants in the 2 hour plus roundtable discussion included: representatives from six VSOs (American Legion, DAV, IAVA, PVA, VFW, VVA); along with representatives from the RAND Corporation, The Elizabeth Dole Foundation, Wounded Warrior Project, the Veterans-Wounded, Ill& Injured Health Care Military Officers Association of America, and the founder of a Veteran advocacy group Veteran Warriors. Chairman Wenstrup noted that demand has continued to outstrip expectations for the Caregiver Support Program and wanted to know if we are setting the right expectation / intent for the program. Ranking Member Brownley said that access to caregivers when they are needed could save dollars by avoiding nursing home admissions. Meg Kabat provided an overview of VA's CPS and said that VA has noted that there

are many who view CSP as a benefit rather than a health care intervention. She continued that VA wants Veterans to be at the highest possible level of functionality and stressed that caregiving occurs in a continuum from phone call reminders to tube feeding and turning. Dr. Richard Allman provide an overview of VA's continuum of long term services and supports that serve the needs of Veterans with impairments in carrying out their day to day activities. Daniel Schoeps described the Veterans Directed Care program, VA's offering for self-directed care, which creates a monthly budget for each Veteran enrolled that allows the Veteran to purchase services to allow them to age at home and keeps the Veteran in charge of their healthcare. He said that younger Veterans have been attracted to the program and that Veterans who like to be in charge do particularly well. Other discussion included: the fact that VA has some excellent facilities that do a stellar job with CSP and some facilities that need to look at best practices at the excellent facilities; identifying alternative pathways they may be more beneficial for some Veterans; educating caregivers who often believe that the stipend path is the only pathway to go down; the need to identify active duty members prior to them transitioning from active duty to Veterans status; the need for consistent standardized forms nationwide; one standard eligibility process; standard appeal process; a uniform assessment process to ensure the same decision, under identical circumstances, regardless of where the Veteran/caregiver reside; and the need for clear concise VA communication in layman's language.³

· April 28, 2017. Dr. Lynda Davis, Chief Veterans Experience Officer, OSVA; at the request of Rep. Gus Bilirakis, met with Mrs. Lauren Price, founder of a Veteran advocacy group called "Veteran Warriors" to hear Mrs. Price's findings regarding the VA Caregiver Support Program.

9:30 A.M.; VACO, Room 523

POCs: (b)(6)

Summary: No summary will be provided for this event.

· April 28, 2017. Dr. Skye McDougall, VISN 16 Network Director; Richard Crockett, Acting Medical Center Director, Shreveport; Dr. John Areno, Chief of Staff, Shreveport; and Jon Zivony, Program Analyst (SAIL Data Expert) met with Sen. Bill Cassidy to provide an update on issues at the Shreveport VAMC. (Follow-up to March 3, 2017, meeting).

9:15; A.M.; 520 Hart

POC: (b)(6)

Summary: Senator Cassidy said that he had just been in Shreveport talking with private sector providers who were speaking of the Shreveport VAMC's sense of mission. Dr. McDougall advised him that the former VAMC director is no longer a Federal employee. The good news is that the quality scores made a dramatic improvement. The pharmacy review is almost complete and she is holding people accountable. She has reviewed OIG's draft report which she characterized as "a balanced, fair report which acknowledges that most recommended actions have already been taken" and more important states that "no patients were injured". Dr. John Areno and Jon Zivony went over Shreveport's SAIL data, including the multiple facets of access. For approximately two years the mental health access and consultative service program has been setup to see anyone who comes in within an hour. Senator Cassidy recalled that the IG indicated absenteeism was an issue in EMS and asked if Shreveport had the authority to enforce absenteeism. "You bet" was the response, along with an explanation that hiring new leaders was really changing the service and had put the necessary rigor in place. Accountability is now clear and employees know who to ask when they need guidance/direction. Other discussion included: VA's work on reducing opioids and prescription medications, and enhancing complementary and alternative therapies; his interest in getting more VA

the relationship with their academic affiliate LSU, and dual appointments.

· April 28, 2017. Vince Markey, Director, VA Insurance Center; Tim Sirhal, Deputy Director, VA Insurance Center; and Karen Naccarelli, Chief, Insurance Program Management Division, briefed Cecilia Daly of HVAC majority to discuss the details and scope of the TSGLI Year Ten Review report that is anticipated to be available late summer or early fall.

1:00 P.M.; Teleconference

POC: (b)(6)

Summary: VBA experts had an informative discussion with HVAC staff, who seemed interested to learn more about the TSGLI program. HVAC staff expressed concern about high denial rates for claims. The discussion focused on program statistics and public misperceptions of the scope and intent of the program. HVAC staff appreciated the conversation and thanked the experts.

· April 28, 2017. Jake Leinenkugel, White House Senior Advisor, will brief staff from the offices of Rep. McMorris-Rodgers and Rep. Buchanan on the implementation status of the Veterans ID Card Act.

1:00 P.M.; Teleconference

POC: (b)(6)

Summary: Mr. Leinenkugel started the call by providing background on some of VA's past challenges associated with creating a Veterans ID card program, but was quick to assure the staffers that VA indeed has a plan, and that we are moving swiftly to implement. Mr. O'Rourke provided a summary of how VA plans to meet the requirements of the bill but using a third party administrator to print and issue the ID cards as well as verify Veteran status. He also discussed how VA is looking into providing this card at no cost to the Veteran by garnering community partnerships and other internal funding sources. He also shared his goal of producing cards within the next 90 days. Member staff were extremely appreciative of the briefing, offering that this is the first substantial update VA has provided since the law was passed in 2015. They were encouraged about the plan and the way forward, and look forward to working with VA on how they can assist with establishing partnerships within communities or the private sector. Mr. O'Rourke will meet with Rep. Buchanan's staffer again late next week to share some of his partnership ideas.

· April 28, 2017. Meg Kabat, Director, Caregiver Support Program; Elyse Kaplan, Deputy Director, Caregiver Support Program; Pamela Wright, National Program Manager, VA Caregiver Support Line; and Christy Reynolds, Lead Supervisor, VA Caregiver Support Line briefed Laurel Sakai, Sen. Blumenthal, on Caregiver Support Line re: Intimate Partner Violence is Preventable.

2:00 P.M.; Teleconference

POC: (b)(6)

Summary: Simon Coons with SVAC Minority staff also participated in this briefing. VA SMEs described VA efforts to raise awareness of the serious and widespread problem of Intimate Partner Violence (IPV), and how the Caregiver Support Line collaborates with VA's Intimate Partner Violence Assistance Program.

Look Ahead- Monday, May 1, 2017

- May 1, 2017. Dr. Baligh Yehia, Deputy Under Secretary for Health for Community Care, will provide an update on VA's efforts to provide care in the community (Choice 2.0) to 4-Corners Professional Staff Members.

10:30 A.M.; 418 Russell

POC: (b)(6)

- May 1, 2017. Dr. Poonam Alaigh, Acting Under Secretary for Health, will meet with Rep Brad Wenstrup for an introductory office call as well as discussion on VHA's top priorities to include access to care and care in the community.

1:00 P.M.; 1019 Longworth

POC: (b)(6)

Government Accountability Office (GAO) Activity:

Exit Conferences

- May 1, 2017. GAO is ready to present their findings on their review on The AVO and BVO Programs (GAO Code 101052). GAO conducted this review in response to a request made by the House Committee on Veterans' Affairs.

GAO's objectives:

- To what extent did the Department of Veterans Affairs (VA) use fiscal year 2014-2016 funding to offer the AVO and BVO programs?

- What additional internal controls has VA instituted for the AVO and BVO programs since 2015?

12:30 P.M.; VACO, Room 530

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· May 2, 2017. The House Veterans' Affairs Committee will hold a legislative hearing on a draft bill entitled the "Veterans Appeals Improvement and Modernization Act." VA witnesses have not been finalized.

10:00 a.m., Cannon 334

POC: (b)(6)

· May 2, 2017. HVAC-Health will conduct an oversight hearing on lower extremity injuries and also discuss H.R. 1058, the VA Provider Equity Act to receive VA views on this proposed legislation. VA received the invitation letter on April 25, 2017.

2:00 P.M.; 334 Cannon

POC: (b)(6)

· May 3, 2017. The House Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's FY2018 budget.

Time 10:00 A.M.; Location Rayburn 2359

POC: Office of Management, (b)(6) (b)(6) (b)(6)

Testimony Status: in development

· May 4, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on telehealth/telemedicine.

Time TBD; Location TBD

POC: Office of Management

Testimony Status: in development

· May 10, 2017. SVAC will have an oversight hearing on VA's Choice Program and the Future of Choice and care in the community. The committee has asked Secretary Shulkin to be VA's lead witness.

2:30 P.M., 418 Russell Senate Office Building

POC: (b)(6)

· May 11, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on the Veterans Choice Program and the future of non-VA care after that program ends.

Time 10:30am Location Dirksen 124

POC: Office of Management, (b)(6) (b)(6) (b)(6)

Testimony Status: in development

· May 17, 2017. SVAC intends to hold a legislative hearing on the draft agenda set out below. Lead Witness Jennifer S. Lee, M.D., Deputy Under Secretary for Health For Policy and Services, Veterans Health Administration. Accompanied by: Margaret Kabat, National Director, Caregiver Support Program, Veterans Health Administration; Jan Frye, Deputy Assistant Secretary, Office of Acquisition and Logistics, Office of Acquisition, Logistics, and Construction; and James Ruhlman, Assistant Director for Policy & Procedures, Veterans Benefit Administration.

2:30 P.M.; 412 Russell SOB

POC (b)(6)

Tentative Agenda

- S. 23, Biological Implant Tracking and Veteran Safety Act of 2017 (Cassidy, Tester)
- S. 112, Creating a Reliable Environment for Veterans' Dependents Act (Heller, Murray)
- S. 324, State Veterans Home Adult Day Health Care Improvement Act (Hatch/Hirono, Boozman, Heller, Tillis)
- S. 543, Performance Accountability and Contractor Transparency Act of 2017 (Tester, Murray, Manchin)
- S. 591, Military and Veteran Caregivers Services Improvement Act of 2017 (Murray, Tester, Sanders, Brown, Blumenthal, Hirono, Manchin)
- S. 609, Chiropractic Care Available to All Veterans Act of 2017 (Moran, Tester, Blumenthal, Brown)
- S. 681, Deborah Sampson Act (Tester/Boozman, Murray, Blumenthal, Brown)
- S. 764, Veterans Education Priority Enrollment Act of 2017 (Brown, Tillis)
- S. 784, Veterans' Compensation Cost-of-Living Adjustment Act of 2017 (Isakson/Tester)
- S. 804, Women Veterans Access to Quality Care Act (Heller)
- S. 899, Serving our Rural Veterans Act (Sullivan, Tester)
- S. ___, Veteran Partners' Efforts to Enhance Reintegration Act (Blumenthal)
- S. ___, Department of Veterans Affairs Veteran Transition Improvement Act (Hirono)

May 24, 2017. (Tentative). HVAC intends to hold a hearing on VA's FY2018 budget request.

Time and Location TBD

POC: Office of Management

*POSTPONED TBD. The HVAC EO Subcommittee intends to hold a legislative hearing on the agenda set out below. Curtis Coy, Deputy Under Secretary for Economic Opportunity will be representing the VA.

Agenda

*H.R. 43 - To authorize the use of Post-9/11 Educational Assistance to pursue independent study programs.

*H.R. 245 - Veterans' Education Equity Act.

*H.R. 1104 - Veterans To Enhance Studies Through Accessibility Act.

*H.R. 1112 - Shauna Hill Post 9/11 Education Benefits Transferability Act.

*H.R. 1216 - Protecting Veterans From School Closures Act of 2017

*H.R. 1331 - Veterans Success on Campus Act of 2017.

*H.R. 1384 - Reserve Component Benefits Parity Act

*H.R. 1793 - Veteran Education Priority Enrollment Act of 2017

*H.R. 1956 - To increase the amounts of educational assistance payable under Survivors' and Dependents' Educational Assistance Program of the Department of Veterans Affairs.

*H.R. 1989 - Veteran Employment Through Technology Education Courses Act.

*H.R. 1994 - Vocational Education and Training Enhancement for Reintegration Assistance Now Act

*H.R. 2099 - GI Bill Fairness Act of 2017.

*H.R. 2100 - Work-Study for Student Veterans Act.

*H.R. 2103 - To include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program.

*H.R. 2108 - GI Bill STEM Extension Act of 2017.

*Draft Bill - GI Bill Processing Improvement Act.

*Draft Bill - To consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of the Department of Veterans Affairs.

*Draft Bill - To provide for an election requirement and reduction in basic pay for members of the Armed Forces entitled to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program.

POC: (b)(6)

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

HVAC Minority Member Retreat

Meeting

5/1/2017

VA Priorities - Armed Forces Retirement Home (Washington, DC)

Chair Miller Portrait Unveiling

Reception

5/3/2017

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Women's Caucus

Sen

Sanders

Bernie

VT

Meeting

5/4/2017

Privatization, Choice Reschedule from 3/23 and 4/6

Sen/Rep

Thune

Rounds

Noem

SD

Meeting

5/4/2017

Black Hills

Rep

Mast

Brian

FL

Meeting

5/23/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

5/23/2017

Access to Care in the Northern Marianas Islands

Rep

Bergman

Jack

MI

Meeting

5/23/2017

VA Priorities Rescheduled from 3/15

Rep

Brownley

Julia

CA

Meeting

5/23/2017

VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict

Rep

Arrington

Jodey

TX

Meeting

5/23/2017

VA Priorities - Proactive

GI Film Festival

Reception

5/24/2017

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Kihuen

Ruben

NV

Meeting

4/4/2017

Closure of Ely, NV Clinic

Attachments:

Stand up -May 1.docx (192005 Bytes)

image001.emz (4088 Bytes)

image002.png (4841 Bytes)

Owner: (b)(6) (b)(6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Fri Apr 28 15:43:30 CDT 2017

Document ID: 0.7.10678.750063-000001

Attachment Name: EAS

Locator: esapst/*:\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5da4832b00: :0700683cde278f39a0dbb626a7079f28391ea23c92fba13443ed8d8e478abadf13ac

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) /o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b)(6)
To:
Cc:
Bcc:
Subject: Morning Report 4/24/2017
Date: Fri Apr 21 2017 16:01:30 CDT
Attachments: EAS

All,

Attached is the Morning Report for Monday, April 24, 2017. This document is for internal use only.

(b)(6)

Program Analyst, Corporate Enterprise
Office of Congressional and Legislative Affairs
Department of Veterans Affairs
810 Vermont Ave., NW
Desk: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Monday, April 24, 2017

Hot Issues

- April 28, 2017. HVAC Ranking Member Walz and committee members Representatives Kuster, Takano, Brownley, and O'Rourke, along with Representatives Connolly (VA) and Holmes Norton (DC) will visit DC VA Medical Center for a walking tour and an update on VA's response to the IG Report on Health Care Inspection at the Medical Center.

8:00-10:00 A.M.; DC VAMC

POC: (b)(6)

Emerging

- None

Congressional Letters and Meeting Requests Received

- April 20, 2017. Sen Tammy Baldwin (D-WI) expressed support for BraveHearts' grant application.
 - o Received April 21, 2017; VAIQ 7791103.
- April 20, 2017. Sens Patty Murray (D-WA), Maria Cantwell (D-WA) and Reps (Denny Heck (D-WA), and Derek Kilmer (D-WA) expressed support for Metro Parks Tacoma's grant application.
 - o Received April 21, 2017; VAIQ 7791101.

Friday, April 21, 2017 Events

- April 20, 2017. SVAC staff members Jillian Workman and Eric Gardiner traveled to VA's National Center on Homelessness Among Veterans and the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, PA to conduct routine oversight.

POC: (b)(6)

Summary: The staff first received a brief from the National Center on Homelessness (NCHV) on the organization's mission, history, structure, policy impacts and future directions. The staff was particularly interested in the NCHV's pilot programs and any expansion efforts that could include Montana and Georgia. NCHV also explained they were moving towards exploring certificate program possibilities, applying research findings in the field and assuring collaboration between federal and non-federal homeless providers.

After the brief by NCHV, the staff received an overview and discussed care in the community with the facility's leadership. The facility's leader explained that of the 74,801 pending appointments for PVAMC and surrounding CBOCs, 95.5% of all appointments are scheduled within 30 days of the patient's desired date. The facility at the staff's request discussed barriers in the Choice program including the types of complaints they sent to HealthNet. The Committee requested a breakdown of the complaints issued to HealthNet. The staff also toured the Scheduling Call Center, Emergency Department, Behavioral Health Department and Women's Clinic. The staff was impressed by the tour and expressed interest in having Senator Tester attend the Women Veteran's Health Center Dedication on May 5th, 2017.

*April 21, 2017. Craig Robinson, ADAS for National Healthcare Acquisitions; Steve Thomas, Director, National Contracting Service, 90N-P, Office of Acquisition & Logistics and John DuFon, Chief Logistics Officer, VHA briefed HVAC O&I Contracts Investigator, Bill Mallison, on the procurement of High Tech Medical Equipment.

11:00 A.M.; Teleconference

POC: (b)(6)

Summary: HVAC staff reiterated its concern regarding the process by which the NAC purchases high tech medical equipment for VHA facilities in the wake of last year's SCOTUS decision on Kingdomware. The staff inquired about the delays with the Consolidation RFQ originally scheduled for 2016 and asked to review the business case for award. VA staff provided an update on the schedule and explained the business case is still in development.

GAO Activities

Entrance Conference

· April 21, 2017. GAO presented its findings on Federal Government Efforts to Reduce the Use of Social Security Numbers (GAO job code 100830). GAO conducted this review in response to a request made by the Chair of the House Committee on Oversight and Government Reform and the Chair of the Subcommittee on Social Security from the House Committee on Ways and Means.

GAO's objectives were to examine:

- To what extent have agencies developed and executed plans to eliminate the use and display of SSNs?
- What government-wide initiatives have been undertaken to assist agencies in eliminating their unnecessary use of SSNs and what have been their results?

- What remaining challenges have agencies identified to reducing the continued use of SSNs as personal identifiers?

Summary: GAO provided a statement of facts prior to the meeting that was discussed at a high level. GAO anticipates providing its draft report late May 2017 and allowing 30 days to comment. GAO stated they do not anticipate making any recommendations to VA.

GAO anticipates issuing their final report by August 2017.

Look Ahead- Monday, April 24, 2017

- April 24, 2017. Ron Burke, Assistant Under Secretary for Field Operations VBACO, Eric Mandle, Consultant, Compensation Service, VBA and Brad Flohr, Senior Advisor for Compensation Service, VBA will speak with Mr. Chad Sydnor and staff members from Sen. Burr's(NC) office regarding status update on Camp Lejeune process of claims and benefits.

2:00 P.M.

POC: (b)(6)

- April 24, 2017. Representatives of the Board of Veterans Appeals and the Veterans Benefits Administration, as well as staff from the Office of Management, meet with Senate Veterans Affairs Committee and Senate MilCon/VA Appropriations Committee staff regarding appeals modernization legislation.

4:00 P.M.; 418 Russell

POC: (b)(6)

- April 24, 2017. Representatives of the Board of Veterans Appeals and the Veterans Benefits Administration will meet with Senate Veterans Affairs Committee and House Veterans' Disability Assistance and Memorial Affairs Majority staff regarding appeals modernization legislation, including a planned May 2 House Veterans' Affairs Committee hearing on that topic.

5:15 P.M.; 338 Cannon

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

*POSTPONED TBD. The HVAC EO Subcommittee intends to hold a legislative hearing on the agenda

set out below. Curtis Coy, Deputy Under Secretary for Economic Opportunity will be representing the VA.

Agenda

*H.R. 43 - To authorize the use of Post-9/11 Educational Assistance to pursue independent study programs.

*H.R. 245 - Veterans' Education Equity Act.

*H.R. 1104 - Veterans To Enhance Studies Through Accessibility Act.

*H.R. 1112 - Shauna Hill Post 9/11 Education Benefits Transferability Act.

*H.R. 1216 - Protecting Veterans From School Closures Act of 2017

*H.R. 1331 - Veterans Success on Campus Act of 2017.

*H.R. 1384 - Reserve Component Benefits Parity Act

*H.R. 1793 - Veteran Education Priority Enrollment Act of 2017

*H.R. 1956 - To increase the amounts of educational assistance payable under Survivors' and Dependents' Educational Assistance Program of the Department of Veterans Affairs.

*H.R. 1989 - Veteran Employment Through Technology Education Courses Act.

*H.R. 1994 - Vocational Education and Training Enhancement for Reintegration Assistance Now Act

*H.R. 2099 - GI Bill Fairness Act of 2017.

*H.R. 2100 - Work-Study for Student Veterans Act.

*H.R. 2103 - To include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program.

*H.R. 2108 - GI Bill STEM Extension Act of 2017.

*Draft Bill - GI Bill Processing Improvement Act.

*Draft Bill - To consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of the Department of Veterans Affairs.

*Draft Bill - To provide for an election requirement and reduction in basic pay for members of the Armed Forces entitled to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program.

POC: (b)(6)

· April 26, 2017. The Senate Homeland Security and Governmental Affairs Committee intends to hold a hearing on construction of VA medical facilities.

10:00 A.M., 342 Dirksen.

POC: (b)(6)

· April 27, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's suicide prevention efforts.

Time 10:30 A.M.; Location Dirksen 124

POC: Office of Management, (b)(6) (b)(6) 1 (b)(6)

Testimony Status: in development

· May 2, 2017. The House Veterans' Affairs Committee will hold a legislative hearing on a draft bill entitled the "Veterans Appeals Improvement and Modernization Act." VA witnesses have not been finalized.

10:00 a.m., Cannon 334

POC: (b)(6)

· May 3, 2017. The House Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's FY2018 budget.

Time 10:00 A.M.; Location Rayburn 2359

POC: Office of Management, (b)(6) (b)(6) 1 (b)(6)

Testimony Status: in development

+

· May 4, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on telehealth/telemedicine.

Time TBD.; Location TBD

POC: Office of Management

Testimony Status: in development

· May 10, 2017. SVAC will have an oversight hearing on VA's Choice Program and the Future of Choice and care in the community. The committee has asked Secretary Shulkin to be VA's lead witness.

2:30 P.M., 418 Russell Senate Office Building

POC: (b)(6)

· May 11, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on the Veterans Choice Program and the future of non-VA care after that program ends.

Time 10:30am Location Dirksen 124

POC: Office of Management, (b)(6) (b)(6) 1 (b)(6)

Testimony Status: in development

· May 17, 2017. SVAC intends to hold a legislative hearing on the draft agenda set out below. Lead Witness Jennifer S. Lee, M.D., Deputy Under Secretary for Health For Policy and Services, Veterans Health Administration. Accompanied by: Margaret Kabat, National Director, Caregiver

Support Program, Veterans Health Administration; Jan Frye, Deputy Assistant Secretary, Office of Acquisition and Logistics, Office of Acquisition, Logistics, and Construction; and James Ruhlman, Assistant Director for Policy & Procedures, Veterans Benefit Administration.

2:30 P.M.; 412 Russell SOB

POC: (b)(6)

Tentative Agenda

- S. 23, Biological Implant Tracking and Veteran Safety Act of 2017 (Cassidy, Tester)
- S. 112, Creating a Reliable Environment for Veterans' Dependents Act (Heller, Murray)
- S. 324, State Veterans Home Adult Day Health Care Improvement Act (Hatch/Hirono, Boozman, Heller, Tillis)
- S. 543, Performance Accountability and Contractor Transparency Act of 2017 (Tester, Murray, Manchin)
- S. 591, Military and Veteran Caregivers Services Improvement Act of 2017 (Murray, Tester, Sanders, Brown, Blumenthal, Hirono, Manchin)
- S. 609, Chiropractic Care Available to All Veterans Act of 2017 (Moran, Tester, Blumenthal, Brown)
- S. 681, Deborah Sampson Act (Tester/Boozman, Murray, Blumenthal, Brown)
- S. 764, Veterans Education Priority Enrollment Act of 2017 (Brown, Tillis)
- S. 784, Veterans' Compensation Cost-of-Living Adjustment Act of 2017 (Isakson/Tester)
- S. 804, Women Veterans Access to Quality Care Act (Heller)
- S. 899, Serving our Rural Veterans Act (Sullivan, Tester)
- S. ___, Veteran Partners' Efforts to Enhance Reintegration Act (Blumenthal)
- S. ___, Department of Veterans Affairs Veteran Transition Improvement Act (Hirono)

- May 24, 2017. (tentative). HVAC intends to hold a hearing on VA's FY2018 budget request.

Time and Location TBD

POC: Office of Management

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

Rep

Arrington

Jodey

TX

Meeting

4/27/2017

VA Priorities - Proactive

HVAC Minority Member Retreat

Meeting

5/1/2017

VA Priorities - Armed Forces Retirement Home (Washington, DC)

Chair Miller Portrait Unveiling

Reception

5/3/2017

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Sen

Sanders

Bernie

VT

Meeting

5/4/2017

Privatization, Choice Reschedule from 3/23 and 4/6

Sen/Rep

Thune

Rounds

Noem

SD

Meeting

5/4/2017

Black Hills

GI Film Festival

Reception

5/24/2017

Rep

Brownley

Julia

CA

Meeting

3/28/2017

VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Kihuen

Ruben

NV

Meeting

4/4/2017

Closure of Ely, NV Clinic

Attachments:

Stand up -April 24.docx (191678 Bytes)

image001.emz (4118 Bytes)

image002.png (4725 Bytes)

Owner: (b)(6) (b)(6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Fri Apr 21 16:01:30 CDT 2017

Document ID: 0.7.10678.747228-000001

Attachment Name: EAS

Locator: es:\pst*\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5d84b42b00: :0700f7f4977f8c52115d9f14c742dddb2d7242c189d0c8355985b6cc3b2b0e3e0117

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report 4/21/2017
Date: Thu Apr 20 2017 15:56:58 CDT
Attachments: EAS

All,

Attached is the Morning Report for Friday, April 21, 2017. This document is for internal use only.

(b)(6)

Program Analyst, Corporate Enterprise
Office of Congressional and Legislative Affairs
Department of Veterans Affairs
810 Vermont Ave., NW
Desk: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Friday, April 21, 2017

Hot Issues

- None

Emerging

- None

Congressional Letters and Meeting Requests Received

*April 5, 2017. Sen. Lindsey Graham (R-SC) expressed support of the nomination of LaDonna Ryggs.

*Received April 20, 2017; VAIQ 7790162.

*April 17, 2017. Rep. Walter Jones (R-NC) passed on concerns regarding information giving to him by a Veteran constituent.

*Received April 20, 2017; VAIQ 7790842.

*April 18, 2017. Rep. John Ratcliffe (R-TX) expressed concern in VA's handling of Veterans seeking organ transplants.

*Received April 20, 2017; VAIQ 7790378.

*April 19, 2017. Ranking Member Ann Kuster (HVAO O&I) requested information regarding logistical services at the DC VAMC.

*Received April 20, 2017; VAIQ 7790789.

*April 20, 2017. Rep. Frank LoBiondo (R-NJ) requested consideration for a CBOC in his district.

*Received April 20, 2017; VAIQ 7790831.

Thursday, April 20, 2017 Events

· April 19, 2017. Ms. Gloria A. Williams, Director External Accreditation Programs, spoke with Ms. Tamara Bonzanto, HVAC-O&I concerning how the Veterans Health Administration tracks and utilizes information from Joint Commission reports to improve VA's health care system.

2:00 P.M.; Teleconference

POC: (b)(6)

Summary: Ms. Tamara Bonzanto, HVAC-O&I requested a call with VA's liaison with the Joint Commission (JC). Ms. Bonzanto mentioned a recent site visit to the DC VA medical center and concern after learning JC and VA's Office of Inspector General (OIG) were on site at the same time but reported differing assessments of the facility. Ms. Williams described her roles and where the External Accreditation Program office sits within VHA. Dr. Shereef Elnahal, Assistant Deputy Under Secretary for Quality Safety and Value, also was on line. Ms. Williams explained that as VA's JC Liaison she has access to ExtraNet where JC posts its survey reports in real time and how this information is information is then aggregated and disseminated to facilities, VISNs and VHA Program Offices and Operations. Ms. Williams also explained that while JC conducts triennial reviews, JC visits are unannounced and are of a more limited scope than an OIG investigation. In recent months staff has been tasked to cross check JC survey reports with OIG, Government Accountability Office and other quality and safety reviews. Ms. Bonzanto expressed concern whether JC was looking at the right things. Ms. Bonzanto asked to see a copy of the monthly report for December 2016, which would incorporate the findings from the full year.

· April 19, 2017. Danny Devine, Deputy Director of Policy and Procedures, Compensation Service, VBA; Johnathan Huges, Chief, Compensation Service, VBA and Roberta Lowe, Acting Director, DMC, briefed SVAC minority staff and members of Sen. Tester's staff on VA's debt management and reimbursement process .

4:00 P.M.; teleconference

POC: (b)(6)

Summary: The intent of this briefing was to a general overview regarding how debt are incurred and the reimbursement process. SVAC staff only expressed an interest in the number of debt notification letters sent to Veterans; staff inquired why two letters must be sent vice one letter including the information provided on the second letter.

· April 20, 2017. Greg Giddens, Executive Director, OALC met with SVAC Minority Staff Member, Jon Coen, to discuss acquisition and procurement programs.

11:00 A.M.; 825A Hart

POC: (b)(6)

Summary: This cordial meeting was purposed to be an introductory call by Mr. Giddens for Mr. Coen and Mr. Coon who are both new to the committee staff. Mr. Giddens provided a high-level overview of various efforts within OALC to improve VA's supply chain management and acquisition workforce. Other topics included VA's relationship with the U.S. Army Corp of Engineers, changes in construction management, and leasing. Mr. Giddens also provided information on his new assignment leading the Office of Modernization

· April 20, 2017. Penny Nechanicky, National Director of Prosthetic and Sensory Aids Service; and Ricky Lemmon, Acting Chief Procurement and Logistics Officer; briefed Rep. Jack Berman's office on VA's Prosthetic and Sensory Aids Service and prosthetic device over \$3500 which must be purchased through an acquisition plan.

12:30 P.M.; Teleconference

POC: (b)(6)

Summary: This was an information briefing to provide basic information on the Prosthetic and Sensory Aids Service (PSAS) and to convey specific information on the prosthetic appliance acquisition process. PSAS provides medically appropriate equipment, supplies and services that optimize Veterans health and independence. Ms. Nechanicky told him that prosthetics in VA is much larger than in the community and includes assistance ranging from vision, hearing, speech/language, swallowing, cognitive impairment, to TBI and more. Approximately 52 percent of all Veterans enrolled in VHA healthcare receive PSAS items. In FY 2016, PSAS provided 20,001,226 items / devices to more 3.3 million Veterans. Ninety-seven percent of all PSAS items provided are below the Micro-Purchase Threshold level which is \$3500. Mr. Rick Lemmon delineated the Federal Acquisition Regulation (FAR) requirements and discussed the timeline and process to obtain a prosthetic device over \$3500 which must be purchased by a warranted contracting officer through an acquisition plan. Other discussion included: that VA is working to put items/devices on contract so we know the Veteran gets a high quality product at a good price as quickly as possible; that all requests begin when the Veteran sees a clinical provider who then writes a prescription to PSAS for a clinically appropriate device; and the timelines for the devices when below and when above the \$3500 threshold.

Look Ahead- Friday, April 21, 2017

· April 21, 2017. Craig Robinson, ADAS for National Healthcare Acquisitions; Steve Thomas, Director, National Contracting Service, 90N-P, Office of Acquisition & Logistics and John DuFon, Chief Logistics Officer, VHA will brief HVAC staff on the procurement of High Tech Medical Equipment.

11:00 A.M.; Teleconference

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· April 26, 2017. The HVAC EO Subcommittee will intend to hold a legislative hearing on the agenda set out below. Curtis Coy, Deputy Under Secretary for Economic Opportunity will be representing the VA.

Agenda

o H.R. 43 - To authorize the use of Post-9/11 Educational Assistance to pursue independent study

programs.

- o H.R. 245 - Veterans' Education Equity Act.
- o H.R. 1104 - Veterans To Enhance Studies Through Accessibility Act.
- o H.R. 1112 - Shauna Hill Post 9/11 Education Benefits Transferability Act.
- o H.R. 1216 - Protecting Veterans From School Closures Act of 2017
- o H.R. 1331 - Veterans Success on Campus Act of 2017.
- o H.R. 1384 - Reserve Component Benefits Parity Act
- o H.R. 1793 - Veteran Education Priority Enrollment Act of 2017
- o H.R. 1956 - To increase the amounts of educational assistance payable under Survivors' and Dependents' Educational Assistance Program of the Department of Veterans Affairs.
- o H.R. 1989 - Veteran Employment Through Technology Education Courses Act.
- o H.R. 1994 - Vocational Education and Training Enhancement for Reintegration Assistance Now Act
- o H.R. 2099 - GI Bill Fairness Act of 2017.
- o H.R. 2100 - Work-Study for Student Veterans Act.
- o H.R. 2103 - To include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program.
- o Draft Bill - GI Bill Processing Improvement Act.
- o Draft Bill - GI Bill STEM Extension Act of 2017.
- o Draft Bill - To consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of the Department of Veterans Affairs.
- o Draft Bill - To provide for an election requirement and reduction in basic pay for members of the Armed Forces entitled to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program.

10:00 A.M.; Cannon 334

POC: (b)(6)

· April 26, 2017 POSTPONED to May 17, 2017. SVAC intends to hold a legislative hearing on the draft agenda set out below. Lead Witness Jennifer S. Lee, M.D., Deputy Under Secretary for Health For Policy and Services, Veterans Health Administration. Accompanied by: Margaret Kabat, National Director, Caregiver Support Program, Veterans Health Administration; Jan Frye, Deputy Assistant Secretary, Office of Acquisition and Logistics, Office of Acquisition, Logistics, and Construction; and James Ruhlman, Assistant Director for Policy & Procedures, Veterans Benefit Administration.

2:30 P.M.; 412 Russell SOB

POC: (b)(6)

Tentative Agenda

- S. 23, Biological Implant Tracking and Veteran Safety Act of 2017 (Cassidy, Tester)
- S. 112, Creating a Reliable Environment for Veterans' Dependents Act (Heller, Murray)
- S. 324, State Veterans Home Adult Day Health Care Improvement Act (Hatch/Hirono, Boozman, Heller, Tillis)
- S. 543, Performance Accountability and Contractor Transparency Act of 2017 (Tester, Murray, Manchin)
- S. 591, Military and Veteran Caregivers Services Improvement Act of 2017 (Murray, Tester, Sanders, Brown, Blumenthal, Hirono, Manchin)
- S. 609, Chiropractic Care Available to All Veterans Act of 2017 (Moran, Tester, Blumenthal, Brown)
- S. 681, Deborah Sampson Act (Tester/Boozman, Murray, Blumenthal, Brown)
- S. 764, Veterans Education Priority Enrollment Act of 2017 (Brown, Tillis)
- S. 784, Veterans' Compensation Cost-of-Living Adjustment Act of 2017 (Isakson/Tester)
- S. 804, Women Veterans Access to Quality Care Act (Heller)
- S. 899, Serving our Rural Veterans Act (Sullivan, Tester)
- S. ___, Veteran Partners' Efforts to Enhance Reintegration Act (Blumenthal)
- S. ___, Department of Veterans Affairs Veteran Transition Improvement Act (Hirono)

- April 26, 2017. The Senate Homeland Security and Governmental Affairs Committee intends to hold a hearing on construction of VA medical facilities.

10:00 A.M., 342 Dirksen.

POC: (b)(6)

- April 27, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's suicide prevention efforts.

Time 10:30 A.M.; Location Dirksen 124

POC: Office of Management, (b)(6) (b)(6) 1 (b)(6)

Testimony Status: in development

- May 2, 2017 (tentative). HVAC intends to hold a legislative hearing on appeals modernization legislation. VA has not received an invitation nor a draft bill. VA witnesses have not been established.

Time TBD.; Location TBD

POC: (b)(6)

- May 3, 2017. The House Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's FY2018 budget.

Time 10:00 A.M.; Location Rayburn 2359

POC: Office of Management, (b)(6) (b)(6) 1 (b)(6)

Testimony Status: in development

+

- May 4, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on telehealth/telemedicine.

Time TBD.; Location TBD

POC: Office of Management

Testimony Status: in development

- May 10, 2017. SVAC will have an oversight hearing on VA's Choice Program and the Future of Choice and care in the community. The committee has asked Secretary Shulkin to be VA's lead witness.

2:30 P.M., 418 Russell Senate Office Building

POC (b)(6)

- May 11, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on the Veterans Choice Program and the future of non-VA care after that program ends.

Time 10:30am Location Dirksen 124

POC: Office of Management, (b)(6) (b)(6) 1 (b)(6)

Testimony Status: in development

- May 24, 2017. (tentative). HVAC intends to hold a hearing on VA's FY2018 budget request.

Time and Location TBD

POC: Office of Management

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

Rep

Arrington

Jodey

TX

Meeting

4/27/2017

VA Priorities - Proactive

HVAC Minority Member Retreat

Meeting

5/1/2017

VA Priorities - Armed Forces Retirement Home (Washington, DC)

Chair Miller Portrait Unveiling

Reception

5/3/2017

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Sen

Sanders

Bernie

VT

Meeting

5/4/2017

Privatization, Choice Reschedule from 3/23 and 4/6

Sen/Rep

Thune Rounds Noem

SD

Meeting

5/4/2017

Black Hills

GI Film Festival

Reception

5/24/2017

Rep

Brownley

Julia

CA

Meeting

3/28/2017

VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Kihuen

Ruben

NV

Meeting

4/4/2017

Closure of Ely, NV Clinic

Attachments:

Stand up -April 21.docx (191054 Bytes)

image001.emz (3766 Bytes)

image002.png (4826 Bytes)

Owner: (b)(6) (b)(6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Thu Apr 20 15:56:58 CDT 2017

Document ID: 0.7.10678.746559-000001

Attachment Name: EAS

Locator: es:\pst*\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5d84bd2b00: :07001f97ae67c328837cb32f2b82a523afbbb1194af200a5f116ed2a1447374760a5

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) </o=va/ou=va
martinsburg/cn=recipients/cn (b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report 4/17/2017 edited
Date: Fri Apr 14 2017 15:21:45 CDT
Attachments: EAS

All,

The updated Morning Report for Monday, April 17, 2017 is resent with a correction to hearing information (highlighted).

This document is for internal use only.

Sincerely,

(b)(6)

(b)(6)

Director of Operations | Office of Congressional and Legislative Affairs

Department of Veterans Affairs

810 Vermont Avenue, NW

Washington, DC 20420

direct phone (b)(6)

fax: (202) 273- 6792

(b)(6)@va.gov

CONFIDENTIALITY NOTICE: "This e-mail and any attachments are intended only for the use of the addressee(s) named herein and may contain privileged and/or confidential information. If you are not the intended recipient of this e-mail, you are hereby notified that any dissemination, distribution or

copying of this e-mail, and any attachments thereto, is strictly prohibited. If you have received this e-mail in error, please notify me via return e-mail and permanently delete the original and any copy of any e-mail and any printout thereof." Thank you.

From: (b)(6)
Sent: Friday, April 14, 2017 3:24 PM
Subject: Morning Report 4/17/2017

All,

Attached is the Morning Report for Monday, April 17, 2017. This document is for internal use only.

(b)(6)

Program Analyst, Corporate Enterprise
Office of Congressional and Legislative Affairs
Department of Veterans Affairs
810 Vermont Ave., NW
Desk (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Monday, April 17, 2017

Hot Issues

- None

Emerging

- None

Congressional Letters and Meeting Requests Received

*April 14, 2017. Chairman Charles Grassley (Judiciary) requested a review of VA's wait time at the Iowa City and Des Moines VA facilities.

*Received April 14, 2017; No VAIQ.

*April 14, 2017. Chairman Jack Bergman (HVC O&I) requested documents pertaining to the logistics service purchases at the DC VAMC.

*Received April 14, 2017; No VAIQ.

Friday, April 14, 2017 Events

· April 13, 2017. Dr. Jennifer MacDonald VHA's Director of Clinical Innovations and Education, Mr. Chuck Ross VA Office of Acquisition Operations Technology Acquisition Center, and Mr. Colin Nash Office of General Counsel provided a status update to the staff of Rep. Moulton (MA-06) on VA's implementation of the Faster Care for Veterans Act (Public Law 114-286).

4:45 P.M.; Teleconference

POC: (b)(6)

Summary: VA subject matter experts explained that both committees of jurisdiction have been briefed on this material and have been notified that VA anticipates making the award tomorrow. Since PL 114-286 did not appropriate any new funds, VA has identified unobligated funds from other VA programs to support the estimated \$4.6 million base period of the new contract. This summer the Department will announce a decision regarding the way forward with VA's electronic healthcare records system and any decisions regarding options with this contract will be in agreement with this decision and won't occur

until the conclusion of the 18 month pilot period. The staffer is eager to learn of the contract award tomorrow and his office will likely release a statement from the Congressman once the award has been made.

· April 13, 2017. Danny Devine, Deputy Director of Policy and Procedures, Compensation Service, VBA; Andrew Bodyk, External Liaison for Procedures and Roberta Lowe, Acting Director, DMC, will brief Rep. Rutherford's staff on VA's debt management and reimbursement process .

11:00 A.M.; teleconference

POC: (b)(6)

Summary: The intent of this briefing was to a general overview regarding how debt are incurred and the reimbursement process. Rep. Rutherford's staff expressed an interest in the number of debts incurred due to fault of VA; what is contained in a debt notification letter; and if the appeals level is raising since the 2015 GAO report.

· April 13, 2017. Dr. Jennifer MacDonald, VHA's Director of Clinical Innovations and Education, briefed the Senate and House Veterans Affairs Committee staff on complicating factors VA is encountering with implementing the Faster Care Act.

4:00 P.M.; Teleconference

POC: (b)(6)

Summary: Dr. MacDonald informed the staff that VA will make an award for an off-the-shelf online patient self-scheduling system as required by law by the end of the week. The new system will be piloted in no less than three Veterans Integrated Service Networks (VISN). She also told the staff that if the award is protested the project will be delayed until the protest is ruled on. The Congressional Staff requested a copy of the full text of the contract - even if the award is protested. Dr. MacDonald stated since PL 114-286 did not appropriate any new funds, VA has identified unobligated funds from other VA's Medical Appointment Scheduling System (MASS) program to support the estimated \$4.6 million base period of the new contract. The Congressional Staff questioned whether this would delay implementation of MASS to which Dr. MacDonald responded yes.

· April 14, 2017. Ronald Burke, Assistant Deputy Under Secretary, Office of Field Operations, and NWQ, VBA, and Astrid Perez, Deputy Director, NWQ, Office of Field Operations, VBA will provide SVAC Majority staff with a tour of the NWQ Command Center.

10:00 A.M.; 1800 G Street, NW

POC: (b)(6)

Summary: SVAC Majority staff was very grateful for this informal, friendly, and very informative briefing. The briefing consisted of review of numerous NWQ dashboards, and live action simulation of NWQ's capabilities within VBMS. SVAC staff was interested in the frequency NWQ data is updated; if VBA has reached their goal for mandatory overtime, and if employees working in claim award and authorizations are able to assist other employees in claims processing. SVAC staff also asked how many FTE are in the NWQ office.

Look Ahead- Monday, April 17, 2017

- April 17, 2017. Dr. Baligh Yehia, Deputy Under Secretary for Health for Community Care, will provide an informational brief to 4-Corners Professional Staff Members on a Phoenix, AZ, pilot program to provide urgently needed care.

12:30 P.M.; Teleconference

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

- April 26, 2017 (Tentative). The HVAC EO Subcommittee will intends to hold a legislative hearing on the agenda set out below. Curtis Coy, Deputy Under Secretary for Economic Opportunity will be representing the VA.

Agenda

- H.R. 43 - To authorize the use of Post-9/11 Educational Assistance to pursue independent study programs.
- H.R. 245 - Veterans' Education Equity Act.
- H.R. 1104 - Veterans To Enhance Studies Through Accessibility Act.
- H.R. 1112 - Shauna Hill Post p/11 Education Benefits Transferability Act.
- H.R. 1216 - Protecting Veterans From School Closures Act of 2017
- H.R. 1331 - Veterans Success on Campus Act of 2017.
- H.R. 1384 - (Section 6 only), Eligibility of Reserve Component Members for Post-9/11 Educational Assistance.
- H.R. 1793 - Veteran Education Priority Enrollment Act of 2017
- H.R. 1956 - To increase the amounts of educational assistance payable under Survivors' and Dependents' Educational Assistance Program of the Department of Veterans Affairs.
- H.R. 1989 - Veteran Employment Through Technology Education Courses Act.
- H.R. 1994 - Vocational Education and Training Enhancement for Reintegration Assistance Now Act

- Draft Bill - GI Bill Processing Improvement Act.
- Draft Bill - GI Bill STEM Extension Act of 2017.
- Draft Bill - To include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program.
- Draft Bill - To consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of the Department of Veterans Affairs.
- Draft Bill - To provide for an election requirement and reduction in basic pay for members of the Armed Forces entitled to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program.
- Draft Bill - GI Bill Fairness Act of 2017.
- Draft Bill - Work-Study for Student Veterans Act.

10:00 A.M.; Cannon 334

POC: (b)(6)

- April 26, 2017 (tentative). SVAC intends to hold a legislative hearing on the draft agenda set out below. VA witnesses have not been established.

2:30 P.M.; 412 Russell SOB

POC: (b)(6)

Tentative Agenda

- S. 23, Biological Implant Tracking and Veteran Safety Act of 2017 (Cassidy, Tester)
- S. 112, Creating a Reliable Environment for Veterans' Dependents Act (Heller, Murray)
- S. 324, State Veterans Home Adult Day Health Care Improvement Act (Hatch/Hirono, Boozman, Heller, Tillis)
- S. 543, Performance Accountability and Contractor Transparency Act of 2017 (Tester, Murray, Manchin)
- S. 591, Military and Veteran Caregivers Services Improvement Act of 2017 (Murray, Tester, Sanders, Brown, Blumenthal, Hirono, Manchin)
- S. 609, Chiropractic Care Available to All Veterans Act of 2017 (Moran, Tester, Blumenthal, Brown)
- S. 681, Deborah Sampson Act (Tester/Boozman, Murray, Blumenthal, Brown)
- S. 764, Veterans Education Priority Enrollment Act of 2017 (Brown, Tillis)
- S. 784, Veterans' Compensation Cost-of-Living Adjustment Act of 2017 (Isakson/Tester)

- S. 804, Women Veterans Access to Quality Care Act (Heller)
- S. 899, Serving our Rural Veterans Act (Sullivan, Tester)
- S. ____, Veteran Partners' Efforts to Enhance Reintegration Act (Blumenthal)
- S. ____, Department of Veterans Affairs Veteran Transition Improvement Act (Hirono)
- April 27, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's suicide prevention efforts.

Time 10:30 A.M.; Location Dirksen 124

POC: Office of Management, (b)(6) (b)(6) 1 (b)(6)

Testimony Status: in development

- May 2, 2017 (tentative). HVAC intends to hold a legislative hearing on appeals modernization legislation. VA has not received an invitation nor a draft bill. VA witnesses have not been established.

Time TBD.; Location TBD

POC: David Ballenger, 1-6464

- May 3, 2017. The House Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's FY2018 budget.

Time 10:00 A.M.; Location Rayburn 2359

POC: Office of Management, (b)(6) (b)(6) 1 (b)(6)

Testimony Status: in development

- May 4, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on telehealth/telemedicine.

Time TBD.; Location TBD

POC: Office of Management

Testimony Status: in development

- May 10, 2017. SVAC intends to hold a hearing on Community Care.

Time: TBD; Location Russell 418

POC: TBD

Testimony Status: in development

· May 11, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on the Veterans Choice Program and the future of non-VA care after that program ends.

Time 10:30am Location Dirksen 124

POC: Office of Management, (b)(6)

Testimony Status: in development

· May 24, 2017. (tentative). HVAC intends to hold a hearing on VA's FY2018 budget request.

Time and Location TBD

POC: Office of Management

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Bilirakis

Gus

FL

Call

4/18/2017

Hyperbaric-Oxyegen Therapy Haely VAMC

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

HVAC Minority Member Retreat

Meeting

5/1/2017

VA Priorities - Armed Forces Retirement Home (Washington, DC)

Chair Miller Portrait Unveiling

Reception

5/3/2017

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Sen

Sanders

Bernie

VT

Meeting

3/6/2017

5/4/2017

Privatization, Choice Reschedule from 3/23 and 4/6

GI Film Festival

Reception

5/24/2017

Rep

Brownley

Julia

CA

Meeting

3/28/2017

VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities - Proactive

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Kihuen

Ruben

NV

Meeting

4/4/2017

Closure of Ely, NV Clinic

Attachments:

image001.emz (3794 Bytes)

Stand up -April 17_updated.docx (188934 Bytes)

image003.emz (3794 Bytes)

image004.png (4603 Bytes)

Owner: (b)(6) </o=va/ou=va martinsburg/cn=recipients/cn=(b)(6)>
Filename: EAS
Last Modified: Fri Apr 14 15:21:45 CDT 2017

Document ID: 0.7.10678.744940-000001

Attachment Name: EAS

Locator: esapst/*:\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5de4e62b00: :0700f24fcd5cd82e0a8bc3c9d26097148403896e2d30bd48bafc0eff4115275e5312

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) </o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Thursday, April 6, 2017
Date: Wed Apr 05 2017 16:51:46 CDT
Attachments: EAS

All,

Attached is the Morning Report for Thursday, April 6, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Thursday, April 6, 2017

Hot Issues

- April 5, 2017. The House passed S. 544, which had been passed by the Senate on April 3rd. The bill now will be sent to the President for consideration for enactment. If enacted, S. 544 would adjust the termination date for the Veterans Choice Program (the VCP), so that the program expires only when the \$10 billion special fund enacted for the VCP in 2014 is exhausted. Without this change, the VCP will expire on August 7, 2017, even if there are funds remaining in the VCP fund. Thus the bill will allow VA to access all of the funding specially appropriated in 2014 for the Choice program, and also ensure that Veterans' access to care in the community isn't disrupted because of that date-certain termination. The bill would also relieve VA of "secondary payer" rules enacted as part of the VCP that presented VA and Veterans with complications in billing. Finally, the bill would allow streamlined sharing of medical records with providers who treat Veterans.

Emerging

- None

Congressional Letters and Meeting Requests Received

- April 4, 2017. Sen. Lindsey O. Graham (R-SC) expressed his support on the nomination of the Assistant Secretary for Information and Technology, and Chief Information Officer (CIO).
 - o Received: April 5, 2017. VAIQ #7786666.
- April 4, 2017. Rep. Dave Brat (R-VA) expressed concern over Agent Orange exposure.
 - o Received: April 5, 2017 VAIQ #7786844.

Wednesday, April 5, 2017 Events

- April 4, 2017. The Subcommittee on Economic Opportunity of the House Committee on Veterans' Affairs conducted an oversight hearing on "Assessing VA Approved Appraisers and How to Improve the Program for the 21st Century."

Witnesses: Jeff London, Director, and Gerald Kifer, Supervisory Appraiser, VA Home Loan Guaranty Service.

2:45 P.M.; 334 Cannon

POC: (b)(6)

Summary: VBA staff were the main focus of a discussion with the EO Subcommittee members in a hearing on the VA Home Loan appraisal process. HVAC Chairman Roe, EO Chairman Arrington, and EO Ranking Member O'Rourke all praised the Loan Guaranty Program, but expressed concern that the shrinking cadre of appraisers nationwide could increase the time required to complete an appraisal, especially for veterans in rural areas or hot markets. The National Association of Realtors, Appraisal Institute and Clear Capital testified that the appraiser shortage is problematic in some areas and cited several reasons including compensation and regulations. Members asked questions relating to the root causes of the appraiser shortage and a few focused on VA regulations and whether VA had some flexibility to remove regulatory burdens on appraisers and the appraisal process.

· April 5, 2017. The HVAC DAMA Subcommittee held a legislative hearing on the agenda set out below. VA witnesses have not been established.

10:30 A.M.; Room 334 Cannon HOB

POC: (b)(6)

Agenda

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- HR 1564 (Bergman) Beneficial Travel for VBA (authorization fix)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Summary: Today HVAC DAMA held their first legislative hearing under the 115th Congress. The hearing began with short remarks from Subcommittee Chairman Bost who spoke about his bills on the agenda, HR 1328 and HR 1329 and the importance that Congress insure that the annual COLA be passed but that we should look further to what is best for Veterans in the long term which would be a permanent COLA authorization. After his opening remarks the Chairman provided time for each Member who had legislation on the agenda to speak to their bill. The Chairman noted that Representative Walz would not be able to join the hearing today but his statement would be incorporated into the record.

The second panel was VA witnesses who presented testimony and addressed were courteous and based on VA's responses felt they had a better understanding of the issues before them. Many of the questions asked of the Members were directed at the legislation on Blue Water Navy. Members were seeking information related to the scientific evidence and reasoning as to why VA has not applied Agent Orange presumptions to those Veterans known as "Blue Water Veterans". Both Ms. Murphy and Dr. Erickson thoroughly explained the science and past policy related to Blue Water and assured Members

that Secretary Shulkin continues to listen to all stakeholders on this matter and will review all evidence new and old regarding this contingent of Veterans. Rep. Sablan's had specifically requested briefings on the various programs so that he could find ways to better serve his growing Veteran population in the Northern Mariana Islands.

The third panel consisted of Representatives from The American Legion, Vietnam Veterans of America, Veterans of Foreign Wars of the United States, Disabled American Veterans, and John Wells, Military-Veterans Advocacy Inc. Chairman Bost asked the whole panel if they believed that a permanent COLA would be in the best interest of Veterans. American Legion opposed a permanent COLA while the rest of the panel was generally supportive. Both Chairman Bost and Congresswoman Esty focused the majority of their questions on the Blue Water Navy legislation. Both Members were sympathetic and have conveyed that they want to correct any deficiencies there may be in the law regarding Blue Water however, both centered their questions on the Congressional Budget Office's scoring of the legislation. Chairman Bost noted that he understands that the VSO's believe that costs should not be a hold up to moving the legislation. However, he conveyed that the Committee and Congress must consider costs and in doing so he asked the panel if they had suggestions for the over one billion offset necessary to move this legislation. Vietnam Veterans of America noted that there was soreness to tax cuts that were taken during previous war times, but did not offer new taxes as an offset. Mr. Wells on the other hand suggested a separate funding stream should be created and that this could be done by requiring everyone who files a tax return to pay a mandatory \$10 fee that would be contributed to this fund. The Chairman noted that this would require tax reforms and inquired as to whether Mr. Wells has reached out to other Committees such as Ways and Means and Appropriations. He stated he was working on it.

· April 5, 2017. Dr. Jeffrey Milligan, Executive Director North Texas Veterans Health Care System (VHCS) and VA personnel representing VISN 17 conducted a teleconference with Rep. Eddie Bernice Johnson's (D-TX) staff to provide an update on the facility and address any questions or concerns.

3:00 P.M.; Teleconference

POC: (b)(6)

Summary: Mr. Kendrick gave an update on construction. The patient-only 400 car garage is complete and the Emergency Department renovations are on track for completion in the fall 2017. VA's Office of Construction and Facilities Management continues to work with the contractor toward completion of the 1000 car garage. The VAMC is without 3 general surgeons due to retirement and medical purposes and the hospital is working to fill those positions.

Look Ahead- Thursday, April 6, 2017

· April 6, 2017. The HVAC Health Subcommittee intends to hold a markup on various legislation.

8:00 A.M.; 334 Cannon

POC: (b)(6)

Agenda

- H.R. 91, the Building Supportive Networks for Women Veterans Act (Rep. Brownley)
- H.R. 95, the Veterans' Access to Child Care Act (Rep. Brownley)
- H.R. 467, the VA Scheduling Accountability Act (Rep. Walorski)
- H.R. 907 the Newborn Care Improvement Act (Rep. Collins)
- H.R. 918, the Veteran Urgent Access to Mental Healthcare Act (Rep. Coffman)
- H.R. 1005, to improve the provision of adult day health care services for veterans (Rep. Zeldin)
- H.R. 1162, the No Hero Left Untreated Act (Rep. Knight)
- H.R. 1545, to clarify VA's authority to disclose certain patient information to State controlled substance monitoring programs (Rep. Kuster)
- H.R. 1662, to prohibit smoking in any facility of the Veterans Health Administration (Rep. Wenstrup)
- H.R. 1848, the Veterans Affairs Medical Scribe Pilot Act of 2017 (Rep. Roe)

· April 6, 2017. Mr. Tom Murphy, Acting Under Secretary for Benefits, and Leadership of the Oakland Regional Office will hold a discussion with the Northern California Delegation, hosted by Congressman Mike Thompson (CA-05) to brief progress at the Oakland Regional Office.

8:00 A.M.; 441 Cannon

POC: (b)(6)

· April 6, 2017. VBA Director Education Service Rob Worley and Assistant Director for Policy and Procedures James Ruhlman will provide an overview briefing on the Accelerated Learning Pilot to SVAC minority staff and HVAC EO Ranking Member O'Rourke staff.

10:00 A.M.; Teleconference

POC: (b)(6)

· April 6, 2017. Dr. Karen Sanders, Deputy Chief Officer, Office of Academic Affiliations (OAA), and Dr. Christopher Clarke, Chief Administrative Officer (OAA) VHA will brief HVAC-Health Majority and Minority Staff on VHA's Graduate Medical Education (GME) Program.

1:00, P.M.; 334 Cannon

POC: (b)(6)

· April 6, 2017. Jim Sullivan, Director, OAEM, Simms, Brett, Director, Capital Asset Management

Service, OAEM and Ed Bradley, Deputy Director, OAEM will speak with Micah Barbour and Rosie Heiss from Sen. Warner's (VA) office regarding authorization of leases.

1:00 P.M.; Teleconference

POC: (b)(6)

· April 6, 2017. Stella Fiotes, Executive Director, Office of Construction & Facilities Management, will provide an update to former Congressman John Mica on the Lake Baldwin (FL) nursing home project.

2:00 P.M.; VACO, RM 511

POC: (b)(6)

· April 6, 2017. Dr. Ashwini Zenooz, MD, Deputy to Deputy Under Secretary for Health Policy and Services, will discuss VA's new policy to provide urgent mental health care to former Servicemembers with other-than-honorable (OTH) administrative discharges with the Senate and House Veterans Affairs Committee staff.

3:00 P.M.; 334 Cannon

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· (Tentative) April 26, 2017. The HVAC EO Subcommittee intends to hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

10:00 A.M.; TBD

POC: (b)(6)

Agenda

· Draft bill, to amend title 38, USC, to consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of Department of

· Draft bill, to amend title 38, USC, to make certain improvements in the administration of the educational assistance programs of the Department

· Draft bill, to direct the Secretary of Veterans Affairs to carry out a high technology education pilot program

· Draft bill, to direct the Secretary of Veterans Affairs to make improvements to the information technology system of the Veterans Benefits

- Draft Bill, to amend title 38, USC, to include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program
- HR 43, to authorize the use of Post-9/11 Educational Assistance to pursue independent study programs at certain educational institutions that are not institutions of higher learning
- HR 245, to provide for the calculation of the amount of the monthly housing stipend payable under the Post-9/11 Educational Assistance Program of the Department of Veterans Affairs based on the location of the campus where classes attended
- HR 1104. To provide for pro-rated charges to entitlement to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program for certain licensure and certification tests and national tests
- HR 1112, to authorize the transfer of unused Post-9/11 Educational Assistance benefits to additional dependents upon the death of the originally designated dependent
- HR 1216, to provide veterans affected by school closures certain relief and restoration of educational benefits
- HR 1331, to direct the Secretary of Veterans Affairs to provide educational and vocational counseling for veterans on campuses of institutions of higher learning
- HR 1384, section 6, eligibility of reserve component members for post 9/11 educational assistance.
- April 26, 2017 (tentative). SVAC intends to hold a legislative hearing on the draft agenda set out below. VA witnesses have not been established.

2:30 P.M.; 412 Russell SOB

POC: (b)(6)

Tentative Agenda

- S. 23, Biological Implant Tracking and Veteran Safety Act of 2017 (Cassidy, Tester)
- S. 112, Creating a Reliable Environment for Veterans' Dependents Act (Heller, Murray)
- S. 324, State Veterans Home Adult Day Health Care Improvement Act (Hatch/Hirono, Boozman, Heller, Tillis)
- S. 543, Performance Accountability and Contractor Transparency Act of 2017 (Tester, Murray, Manchin)
- S. 591, Military and Veteran Caregivers Services Improvement Act of 2017 (Murray, Tester, Sanders, Brown, Blumenthal, Hirono, Manchin)
- S. 609, Chiropractic Care Available to All Veterans Act of 2017 (Moran, Tester, Blumenthal, Brown)

- S. 681, Deborah Sampson Act (Tester/Boozman, Murray, Blumenthal, Brown)
- S. 764, Veterans Education Priority Enrollment Act of 2017 (Brown, Tillis)
- S. 784, Veterans' Compensation Cost-of-Living Adjustment Act of 2017 (Isakson/Tester)
- S. ____, Women Veterans Access to Quality Care Act (Heller)
- S. ____, Serving our Rural Veterans Act (Sullivan, Tester)
- S. ____, Veteran Partners' Efforts to Enhance Reintegration Act (Blumenthal)
- S. ____, Department of Veterans Affairs Veteran Transition Improvement Act (Hirono)

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Sen

Murray

Patty

WA

Meeting

3/8/2017

4/6/2017

Caregivers

Sen

Duckworth

Tammy

IL

Meeting

3/8/2017

4/6/2017

Choice

Sen

Wyden

Ron

OR

Meeting

3/17/2017

4/6/2017

VCL Backup Contract

Sen

Enzi

Michael

WY

Meeting

3/21/2017

4/6/2017

Choice

Rep

O'Rourke

Beto

TX

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

HVAC Minority Member Retreat

Meeting

5/1/2017

VA Priorities - Armed Forces Retirement Home (Washington, DC)

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Sen

Sanders

Bernie

VT

Meeting

3/6/2017

Privatization, Choice Reschedule from 3/23 and 4/6

Rep

Brownley

Julia

CA

Meeting

3/28/2017

VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities - Proactive

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Attachments:

Stand up -April 6.docx (192820 Bytes)

image001.emz (3905 Bytes)

image002.png (4490 Bytes)

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Wed Apr 05 16:51:46 CDT 2017

Document ID: 0.7.10678.741768-000001

Attachment Name: EAS

Locator: esapst/*:\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5de4252c00: :07005298ba4a4bed90e22778729d3d333f57f6a2f6dc1790766c7e506b849655c8fa

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) </o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Wednesday, April 5, 2017
Date: Tue Apr 04 2017 16:41:30 CDT
Attachments: EAS

All,

Attached is the Morning Report for Wednesday, April 5, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Wednesday, April 5, 2017

Hot Issues

- None

Emerging

- None

Congressional Letters and Meeting Requests Received

- April 3, 2017. Rep. Brian Mast (R-FL) expressed concern over the Antimicrobial Stewardship Program.
 - o Received: April 4, 2017. VAIQ #7786375
- April 4, 2017. Sen. Dean Heller (R-NV) expressed concern over the VA Choice Program in Ely, Nevada.
 - o Received: April 4, 2017 VAIQ #7786452

Tuesday, April 4, 2017 Events

- April 4, 2017. The House Committee on Veterans' Affairs conducted a hearing on "An Assessment of Ongoing Concerns at the Veterans Crisis Line."

VA Witnesses: Michael Missal, Inspector General, Office of the Inspector General (OIG); Steve Young, VA Under Secretary for Operations and Management, and Matt Eitutis, VHA

10:00 A.M.; 334 Cannon

POC: (b)(6)

Summary: Inspector General Missal explained that in June 2016, OIG received an allegation related to the experience of a Veteran with the VCL and its backup call centers. As a result of the complaint, and in light of the open recommendations from the OIG's February 2016 report, OIG expanded our scope to conduct an in-depth inspection of the VCL. During their inspections, OIG found organizational deficiencies and foundational problems in the VCL and has provided twenty-three recommendations for improvement. Under Secretary Young stated that action plans have been developed to address all of the recommendations, and VA has requested closure for the six of the initial seven recommendations.

Under Secretary Young also explained why VCL is the strongest it has been since its inception in 2007 such as achieving less than one percent rollover to contracted back-up centers, opening a second VCL site in Atlanta, hiring more crisis intervention responders and forwarding over 416,000 referrals to local Suicide Prevention Coordinators on behalf of Veterans. Witnesses from the Veterans Service Organizations applauded VCL for the progress it has made since the reports were released. Members of Congress questioned how VA plans to make continued improvements to the VCL. Both VSOs and Members stated that VA must improve quality control, implement clinical oversight and increase collaboration between the Office of Member Services, Office of Mental Health Operations and Office of Suicide Prevention. Ranking Member Walz also warned VA not to prematurely declare that VA has solved all the problems with VCL. After the hearing, Chairman Roe expressed his intent to visit both the Atlanta and Canandaigua VCL centers.

· April 4, 2017. The Subcommittee on Economic Opportunity of the House Committee on Veterans' Affairs conducted an oversight hearing on "Assessing VA Approved Appraisers and How to Improve the Program for the 21st Century."

Witnesses: Jeff London, Director, and Gerald Kifer, Supervisory Appraiser, VA Home Loan Guaranty Service.

2:00 P.M.; 334 Cannon

POC (b)(6)

Summary: Due to the timing of the event, a summary will be provided tomorrow's summary.

Government Accountability Office (GAO) Activity:

Exit Conference

· April 4, 2017. GAO presented their findings on "Fiscal Year 2015 Compliance with the Improper Payments Elimination and Recovery Act of 2010 (IPERA)"

(GAO job code 100948). GAO is updating their June 2016 report entitled "Improper Payments: CFO Act Agencies Need to Improve Efforts to Address Compliance Issues" (GAO-16-554) to include fiscal year 2015 data.

GAO's objectives include, but may not be limited to, determining:

(1) The number of agencies, among those listed in the Chief Financial Officers Act of 1990, as amended (CFO Act), that complied with the criteria listed in IPERA, as reported by their Inspectors General (IG), and what criteria and programs the IGs concluded were primarily responsible for instances of agency noncompliance;

- (2) The number of programs at the 24 CFO Act agencies that were determined noncompliant with IPERA criteria by their IGs for 3 or more consecutive years, as of fiscal year 2015, and the extent to which the responsible agencies submitted the required information to Congress and their IGs;
- (3) Whether the IGs adhered to applicable reporting requirements for their fiscal year 2015 IPERA compliance reviews, including reporting on special disaster relief appropriations and OMB-designated high-priority programs;
- (4) What additional procedures, if any, have been performed by the IGs during their IPERA compliance reviews to assess the accuracy and completeness of the agencies' improper payment reporting and performance in reducing and recapturing improper payments; and
- (5) The status of recommendations included in the IGs annual IPERA compliance reviews.

10:30 - 11:30 A.M.; Teleconference

POC: (b)(6)

Summary:

This was a multi-agency exit meeting. GAO provided a statement of facts (SOF) prior to the meeting that was discussed at a high level. In the SOF provided to VA, GAO found that VA IG reports VA as being non-compliant with IPERA overall for the past five years. GAO stated that compliance results were obtained from the IG's annual IPERA compliance reports. Specifically, for Fiscal Year 2015, the information is from the IGS's FY 2015 IPERA compliance report. For the compliance results for Fiscal Years 2011-2014, GAO referred to GAO-16-554, which was previously shared and confirmed with the IGs and/or agencies prior to the report being issued to the public.

GAO stated they anticipate providing their report for comment at the end of April 2017 and allowing 15 days for agencies to comment. GAO will not be making any recommendations to VA.

GAO anticipates issuing its final report in May 2017.

Look Ahead- Wednesday, April 5, 2017

· April 5, 2017. The HVAC DAMA Subcommittee will hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

10:30 A.M.; Room 334 Cannon HOB

POC: (b)(6)

Agenda

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- HR 1564 (Bergman) Beneficial Travel for VBA (authorization fix)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Upcoming Hearings and Testimony Due to Congress

- April 6, 2017. The HVAC Health Subcommittee intends to hold a markup on various legislation.

8:00 A.M.; 334 Cannon

POC: (b)(6)

Agenda

- H.R. 91, the Building Supportive Networks for Women Veterans Act (Rep. Brownley)
- H.R. 95, the Veterans' Access to Child Care Act (Rep. Brownley)
- H.R. 467, the VA Scheduling Accountability Act (Rep. Walorski)
- H.R. 907 the Newborn Care Improvement Act (Rep. Collins)
- H.R. 918, the Veteran Urgent Access to Mental Healthcare Act (Rep. Coffman)
- H.R. 1005, to improve the provision of adult day health care services for veterans (Rep. Zeldin)
- H.R. 1162, the No Hero Left Untreated Act (Rep. Knight)
- H.R. 1545, to clarify VA's authority to disclose certain patient information to State controlled substance monitoring programs (Rep. Kuster)
- H.R. 1662, to prohibit smoking in any facility of the Veterans Health Administration (Rep. Wenstrup)
- H.R. 1848, the Veterans Affairs Medical Scribe Pilot Act of 2017 (Rep. Roe)
- (Tentative) April 26, 2017. The HVAC EO Subcommittee intends to hold a legislative hearing on

the agenda set out below. VA witnesses have not been established.

10:00 A.M.; TBD

POC: (b)(6)

Agenda

- Draft bill, to amend title 38, USC, to consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of Department of
- Draft bill, to amend title 38, USC, to make certain improvements in the administration of the educational assistance programs of the Department
- Draft bill, to direct the Secretary of Veterans Affairs to carry out a high technology education pilot program
- Draft bill, to direct the Secretary of Veterans Affairs to make improvements to the information technology system of the Veterans Benefits
- Draft Bill, to amend title 38, USC, to include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program
- HR 43, to authorize the use of Post-9/11 Educational Assistance to pursue independent study programs at certain educational institutions that are not institutions of higher learning
- HR 245, to provide for the calculation of the amount of the monthly housing stipend payable under the Post-9/11 Educational Assistance Program of the Department of Veterans Affairs based on the location of the campus where classes attended
- HR 1104. To provide for pro-rated charges to entitlement to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program for certain licensure and certification tests and national tests
- HR 1112, to authorize the transfer of unused Post-9/11 Educational Assistance benefits to additional dependents upon the death of the originally designated dependent
- HR 1216, to provide veterans affected by school closures certain relief and restoration of educational benefits
- HR 1331, to direct the Secretary of Veterans Affairs to provide educational and vocational counseling for veterans on campuses of institutions of higher learning
- HR 1384, section 6, eligibility of reserve component members for post 9/11 educational assistance.
- April 26, 2017 (tentative). SVAC intends to hold a legislative hearing on the draft agenda set out below. VA witnesses have not been established.

2:30 P.M.; 412 Russell SOB

POC: (b)(6)

Tentative Agenda

- o S. 23, Biological Implant Tracking and Veteran Safety Act of 2017 (Cassidy, Tester)
- o S. 112, Creating a Reliable Environment for Veterans' Dependents Act (Heller, Murray)
- o S. 324, State Veterans Home Adult Day Health Care Improvement Act (Hatch/Hirono, Boozman, Heller, Tillis)
- o S. 543, Performance Accountability and Contractor Transparency Act of 2017 (Tester, Murray, Manchin)
- o S. 591, Military and Veteran Caregivers Services Improvement Act of 2017 (Murray, Tester, Sanders, Brown, Blumenthal, Hirono, Manchin)
- o S. 609, Chiropractic Care Available to All Veterans Act of 2017 (Moran, Tester, Blumenthal, Brown)
- o S. 681, Deborah Sampson Act (Tester/Boozman, Murray, Blumenthal, Brown)
- o S. 764, Veterans Education Priority Enrollment Act of 2017 (Brown, Tillis)
- o S. 784, Veterans' Compensation Cost-of-Living Adjustment Act of 2017 (Isakson/Tester)
- o S. ___, Women Veterans Access to Quality Care Act (Heller)
- o S. ___, Serving our Rural Veterans Act (Sullivan, Tester)
- o S. ___, Veteran Partners' Efforts to Enhance Reintegration Act (Blumenthal)
- o S. ___, Department of Veterans Affairs Veteran Transition Improvement Act (Hirono)

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Sen

Murray

Patty

WA

Meeting

3/8/2017

4/6/2017

Caregivers

Sen

Duckworth

Tammy

IL

Meeting

3/8/2017

4/6/2017

Choice

Sen

Wyden

Ron

OR

Meeting

3/17/2017

4/6/2017

VCL Backup Contract

Sen

Enzi

Michael

WY

Meeting

3/21/2017

4/6/2017

Choice

Rep

O'Rourke

Beto

TX

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

HVAC Minority Member Retreat

Meeting

5/1/2017

VA Priorities - Armed Forces Retirement Home (Washington, DC)

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Sen

Sanders

Bernie

VT

Meeting

3/6/2017

Privatization, Choice Reschedule from 3/23 and 4/6

Rep

Brownley

Julia

CA

Meeting

3/28/2017

VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities - Proactive

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Young

David

IA

Meeting

3/23/2017

VCL

Attachments:

Stand up -April 5.docx (188957 Bytes)

image001.emz (4076 Bytes)

image002.png (4522 Bytes)

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Tue Apr 04 16:41:30 CDT 2017

Document ID: 0.7.10678.741339-000001

Attachment Name: EAS

Locator: esapst/*:\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5de42e2c00: :07009ee1dfc9a2bac8fbf63ac548f05b61019a830f26f53b5da71c63e7c88090dccc

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) /o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)
To:
Cc:
Bcc:
Subject: Morning Report: Friday, March 24, 2017
Date: Thu Mar 23 2017 17:16:49 CDT
Attachments: EAS

All,

Attached is the Morning Report for Friday, March 24, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Friday, March 24, 2017

Hot Issues

- GAO Final Report on Appeals to be released March 23rd

Emerging

- None

Congressional Letters and Meeting Requests Received

- March 15, 2017. Rep. John Cater (R-TX) expressed concern over organ transplant procedures for Veterans.

- o Received March 23, 2017: VAIQ #7783645

- March 21, 2017. Ranking Member Tim Walz (HVC), and Rep. Richard M. Nolan (D-MN) expressed concern over lodging repairs for the Minnesota Department of Veterans Home in Silver Bay, MN.

- o Received March 23, 2017: VAIQ #7783503

- March 22, 2017. Chairman David P. Roe (HVC) expressed concern in reference to the Veterans Crisis Line back up call center.

- o Received March 23, 2017: VAIQ #7783504

Thursday, March 23, 2017 Events

- March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans Affairs, Subcommittee on Health conducted an oversight hearing on “Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers.”

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

Summary: This was the first hearing held by HVAC Subcommittee on Health for 115th Congress and essentially served as a follow up to a legislative hearing held a year ago that focused on Veterans Health Administration (VHA) hiring. The hearing also was in response to a December 2016 GAO (17-30) report that outlined key challenges in VHA's management of HR policies and operations. All Members were present for at least part of the hearing with one exception – Congresswoman Jenifer Gonzalez (R-PR). Representatives Ann McLane Kuster (D-NH) and Lou Correa (D-CA) left the hearing early and did not question the witnesses. There was a single panel with GAO, American Legion, the Partnership for Public Service and VA at the table. Chairman Wenstrup and Congresswoman Brownley expressed bipartisan support for H.R. 1367, a bill to Improve the Authority of the Secretary of Veterans Affairs to Hire and Retain Physicians and Other Employees and a willingness to work together to help VA overcome its HR challenges. GAO reiterated the report findings noting that problems persist with respect to training of nurse recruiters. The Partnership suggested VA would benefit from partnering with private sector and adapting their recruitment tactics, identifying ways to entice and new graduates to Federal service and normalizing Government processes to hire more executives with private sector expertise. The American Legion noted VHA's has historically had difficulty with succession planning but suggested Congress and others recognize that given VA's distinct and multifaceted mission a direct comparison between VA and private sector entities like Cleveland Clinic is not possible. All witnesses expressed concern about the impact of the Federal hiring freeze and the message it sends to potential candidates. The wide disparity in pay between VA Medical Center and VISN Director and private sector health care executive also frustrates VHA recruitment and retention efforts. All acknowledge that Federal HR process issues as well as the national shortage of health care providers is not unique to VA.

· March 22, 2017. Mr. Steven Young, Deputy Under Secretary for Operations Management, briefed Sen. Wyden's staff on the Veterans Crisis Line back-up call center contracts.

4:00 P.M.; 221 Dirksen

POC: (b)(6)

Summary: Sen Wyden's staffer, Ben Widness, expressed concerns over the Department's recent decision drastically changing the scope of utilization at the Portland VCL Backup Call Center. The call center has been identified as the primary facility to take calls rolled-over in the event of a catastrophe rendering the main service centers inoperable (i.e., power outages). The meeting focused mainly on the backup centers capacity and the way forward for the Portland facility. Mr. Eitutis expanded that the full scope of utilization is still under negotiation as a part of the new contract. The staffer expressed the Senator's concern that staff levels should remain unchanged at the Portland Call Center. Mr. Eitutis conveyed the Department's commitment to ensuring appropriate levels of staff will be maintained, and training would be regularly scheduled. While the information was well received, it is very likely that Mr. Widness will request an update on the status of the contract.

· March 22, 2017. Dr. Yehia, Deputy Under Secretary for Health for Community Care, briefed HVAC Majority staff on a TN VA community care cardiology proposal.

5:00 P.M.; Teleconference

POC: (b)(6)

Summary: Discussion focused on a proposal set forth by a local cardiovascular association (CVA) in concert with Mountain Home VAMC to contract for cardiology services while simultaneously creating a partnership with the CVA as a Choice provider. The early on confusion was that although the interested CVA would want to be enrolled in Choice as well as provide services within the walls of VA, that would be dependent upon their ability to be awarded a contract that is currently in the early stages of development with an RFP in process. Dr. Yehia explained that this would be a local contract and not an issue with VACO's Community Care team. He also stated that neither the local VAMC nor VA could enter into a sole source contract with this CVA. Dr. Yehia is working with the TPA to secure their entry into the Choice program where they could eventually serve as a provider. Staff asked if VA could use Choice funds to pay the CVA's providers to perform services internal to VA's walls given VA lacks staff. Dr. Yehia said that has never been the intent in the past to use Choice funds this way, and VA has never paid a Choice provider to come to a VA facility to provide services but stated this is exactly the type of concept VA should explore in Choice 2.0. He also said he would get OGC to opine on that possibility. Staff agreed that congress in the past had not considered Choice to be utilized that way. However they would support this new approach. Staff also asked how quick the CVA could enroll as a provider as well as how quick VA could not only let out a contract but then award the contract given then CVA's sense of urgency to hire 2 additional physicians. Dr. Yehia reiterated that the contract for services would be part of the normal contract cycle but he could expedite, working with the TPA, the process of enrolling into the Choice network.

· March 23, 2017. Dr. Poonam Alaigh, Acting Undersecretary for Health, Steve Young, Deputy Under Secretary for Health for Operations and Management, and Matt Eitutis, Acting VHA Member Services Executive Director, discussed the OIGs Report on the VHA's Veterans Crisis Line with the 4 Corners PSMs and Sen. Nelson's staffer.

9:30 A.M.; 334 Cannon

POC: (b)(6)

Summary: Dr. Alaigh told the Congressional staff that suicide prevention is one of the Department's highest priorities and she was taking a leadership role in improving the Veterans Crisis Line as a critical step in keeping VA's commitment to Veterans. Mr. Young and Mr. Eitutis explained a series initiatives VA has taken to ensure every caller receives the best customer service possible, making notable advances to improve access and the quality of mental healthcare to Veterans in crisis. The Congressional staff were concerned with reports that clinical input was not being considered when making routine operational decisions. Mr. Eitutis explained that prior to moving VCL operations to Member Services the call roll over rate often exceeded 30%, whereas the current call roll over rate is less than 1%, with over 99% of all calls being answered by the VCL. He also emphasized the Director of VCL has been a clinician and VCL leadership relies on input from the Clinical Advisory Board. The staff were also interested on what effects VA's plan to expand mental health access for OTH Veterans would have on VCL capacity and VA's budget. Dr. Alaigh responded servicemembers may enter the system to use this benefit by calling the VCL and both initiatives are part of the larger Suicide Prevention Initiative.

· March 23, 2017. Ms. Carin Otero, Acting Deputy Assistant Secretary, HR Policy & Planning, HR&A; Ms. Avia Pichon-Cosay, Deputy Associate Chief Officer, HR Operations & Oversight, VHA; Mike Frueh, Chief of Staff, VBA; Ms. Lisa Thomas, Executive Director, Human Capital Management, NCA; and Ms. Rici Mulligan, Executive Director, Budget and Finance, OI&T briefed SVAC Minority staff on "Impact of the Current Hiring Freeze on VA's Exempt and Non-Exempt Vacancies."

11:00 A.M.; Teleconference

POC: (b)(6)

Summary: HR&A, VHA, VBA, NCA, and OI&T responded to questions from SVAC minority staff regarding the status of VA's vacancies exempted from the current hiring freeze. Information regarding the current number of vacancies in relation to the identified positions was given. Staff requested an updated report on VA's exempted positions.

· March 23, 2017. (Postponed - March 13, 2017). Dr. Michael S. Icardi, National Director of Pathology and Laboratory Medicine, Dr. Laurence J. Meyer, National Director Genomic Medicine, Chief Officer Specialty Care Services and Ms. Valerie Miller, Associate Program Manager, Pathology and Laboratory Medicine Services briefed Ms. Dahlia Melendrez, SVAC-D, concerning VA blood sources.

2:30 P.M.; Teleconference

POC: (b)(6)

Summary: VA subject matter experts spoke with Ms. Dahlia Melendrez, SVAC-D about how VA sources blood products. The call was brief and cordial. Dr. Icardi gave a quick overview explaining that VA does not accept blood donations other than ontological donations where a patient donates blood for the patient's own use. VA purchases blood from local blood banks approved by the U.S. Food and Drug Administration (FDA). VA also has a memorandum of understanding with the Department of Defense (DoD) to access surplus DoD blood supplies. All sources and recipients must be FDA approved and undergo rigorous investigations to ensure compliance with all FDA standards and requirements. Should a source lose its accreditation, FDA notifies all that FDA approval has been withdrawn.

Government Accountability Office (GAO) Activity:

Exit Conferences

· March 23, 2017. GAO presented their findings on Veterans Health Administration (VHA) Information Technology (IT) (GAO Code 100436). GAO conducted this review in response to a request made by former Ranking Member Corrine Brown of the House Committee on Veterans' Affairs (HVAC), and Representative Derek Kilmer. Former HVAC Chairman Jeff Miller was added as a co-requester.

11:00 A.M.; VACO, Room 532

POC: (b)(6)

GAO's objectives were to examine:

*The extent to which VHA's current IT systems support the agency's core functions.

*The extent to which VA's IT investment management process ensures that technology investments are prioritized. Selected, executed, and monitored to support VHA's core functions.

GAO's findings:

- The Information Resource Management Strategic Plan does not describe or point to a specific target to be achieved and related performance metrics for how progress against this target will be measured.
- VHA's Health Information Strategic Plan does not identify corresponding performance targets and metrics for strategic goals and objectives identified in the plan.
- OI&T's Multi-Year Programming guidance does not describe what criteria will be used to weigh tradeoffs between investments for selection decisions that determine whether one investment is funded over another and does not address how programs are to be reselected once they are operational.
- The Portfolio Investment Review Board and OI&T have not issued additional guidance or other documentation related to how the new IT governance structure will work to oversee management of IT across the department.
- As of October 2016, VHA had 2,772 requests for IT needs documented in NSR database since 1998. Of these, there are approximately 817 open requests—IT needs identified throughout VHA that have not been met. 316, (39 percent), of open needs have been open for more than 5 years.
- Pharmacy Benefits Management, Scheduling, and Community Care all have open requests that represent long-standing, unmet IT needs.

GAO provided a statement of facts prior to the meeting that VA agreed to provide suggested edits by March 24. GAO stated they anticipate providing their report for comment in early April 2017, making recommendations to VA to address unmet business needs, and allowing 30 days to comment.

GAO anticipates issuing its final report in May 2017.

Look Ahead- Friday, March 24, 2017

- March 24, 2017. Mr. Jim Warner, Chief Learning Officer, EES; Dr. Yasuharu Okuda, SimLEARN Medical Director; and Dr. Harry Robinson, SimLEARN Project Manager, will brief staff from Congresswoman Stephanie Murphy's (D-FL-07) on VA's SimLEARN program.

11:30 A.M.; 1237 Longworth

POC: (b)(6)

- March 24, 2017. Dr. Yehia, Deputy Under Secretary for Health for Community Care, will provide an update to 4-Corners Professional Staff on VA's Choice 2.0 plans.

12:30 P.M.; Teleconference

POC: (b)(6)

- March 24, 2017. BVA and VBA staff will provide a briefing to 4-Corners staff on recent developments related to appeals modernization.

3:00 P.M.; Teleconference

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

- March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

1:30 P.M.; Room: Cannon 334

POC: (b)(6)

- March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.
- H.R. 467 - The VA Scheduling Accountability Act.
- H.R. 907 - The Newborn Care Improvement Act.
- H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
- H.R. 1005 - To improve the provision of adult day health care services for Veterans.
- H.R. 1058 - The VA Provider Equity Act.
- H.R. 1162 - The No Hero Left Untreated Act.

- H.R. 1545- VA Prescription Data Accountability Act of 2017
- Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
- Draft Bill - To prohibit smoking in any VHA facility.

· April 4, 2017. The House Committee on Veterans' Affairs will conduct a hearing on the OIG's Veterans Crisis Line Report.

10:00 A.M.; 334 Cannon

POC: (b)(6)

· April 5, 2017. The HVAC DAMA Subcommittee will hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

10:30 A.M.; Room 334 Cannon HOB

POC: (b)(6)

Agenda

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- HR 1564 (Bergman) Beneficial Travel for VBA (authorization fix)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

McMorris Rogers

Cathy

WA

Meeting

3/24/2017

VA issues and Moving Forward in the 115th

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA Delaware State Veterans Summit

Sen

Klobuchar

Amy

MN

Call

4/4/2017

Burn Pit Legislation

Rep

Brownley

Julia

CA

Meeting

4/4/2017

VA Priorities Rescheduled from 3/15

Rep

Bost

Mike

IL

Meeting

4/4/2017

Appeals Reform Legislation

Rep

O'Rourke

Beto

TX

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Sen

Murray

Patty

WA

Call

3/8/2017

Caregivers

Sen

McCain

John

AZ

Call

3/22/2017

Unknown

Sen

Duckworth

Tammy

IL

Meeting

3/8/2017

TBD

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Wyden

Ron

OR

Meeting

3/17/2017

VCL Backup Contract

Sen

Enzi

Michael

WY

Meeting

3/21/2017

Choice

Sen
Sanders
Bernie
VT
Meeting
3/6/2017

Privatization, Choice Reschedule from 3/23

Sen
Sullivan
Dan
AK
Travel
2/1/2017

SecVA State Visit Request

Sen
Tester
Jon
MT
Travel
2/1/2017

SecVA State Visit Request

Sen
Manchin
Joe
WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Thu Mar 23 17:16:49 CDT 2017

Document ID: 0.7.10678.737311-000001

Attachment Name: EAS

Locator: es:\pst*\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5de47e2c00: :0700048933a2d1e828796129148733a167aa8065e337d81f1dba8d585c3458ec51fb

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) </o=va/ou=yba
philadelphia/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Thursday, March 23, 2017
Date: Wed Mar 22 2017 17:07:50 CDT
Attachments: EAS

All,

Attached is the Morning Report for Thursday, March 23, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Thursday, March 23, 2017

Hot Issues

- GAO Final Report on Appeals to be released March 23rd

Emerging

- None

Congressional Letters and Meeting Requests Received

- March 21, 2017. Chairman Jack Bergman (O&I), and Rep. Mike Coffman (R-CO) expressed concern over a Veteran's pending claim, in addition to side effects from a change in his medication.
 - o Received March 22, 2017: VAIQ #7783112
- March 21, 2017. Rep. Hultgren (R-IL) expressed concern over the use of technology servicing Veterans verses in-person services.
 - o Received March 22, 2017: VAIQ #7783387

Wednesday, March 22, 2017 Events

- March 21, 2017. The HVAC EO Subcommittee held a legislative hearing on a single bill H.R. 1461, entitled the "Veterans, Employees, and Taxpayers Protection Act of 2017," which pertains, in significant part, to the use of official time and probationary employees. VA witnesses are Kimberly Perkins McLeod, Acting Executive Director, Labor Management Relations, accompanied by Rondy Waye, Human Resources Policy Advisor in VA's Office of Human Resources and Management.

2:00 P.M.; Room: 334 Cannon HOB

POC: (b)(6)

Summary: HVAC DAMA held a hearing on H.R. 1461 titled The Veterans Employees and Taxpayer Protection Act of 2017, also called the VET Protection Act. The bill was introduced by Chairman Arrington and though the bill has no co-sponsors, appeared to have full support of the Republican Member on subcommittee. Although the bill has four main components the focus of the Committee was on the provision of limiting official time. Other witnesses at this hearing were: Shirley Parker Blommel,

President, Local 390, St. Cloud VA Health Care System, American Federation of Government Employees and Derk Wilcox, Senior Attorney for the Mackinac Center for Public Policy.

Mrs. McLeod stated the Department's support for all the measures, noting however, that edits would need to be made for the bill to meet the intent noted by the Chairman. Mrs. Parker spoke against the restrictions on official time. Mr. Wilcox supported the all measures of the bill.

A majority of the Members, particularly Ranking Member O'Rourke and Rep. Takano, expressed frustration that the VA has not been adequately keeping track of official time. Mr. Wilcox, one of the witnesses, noted that one million official hours were reported in 2012, costing \$47 million, and that the GAO still believes that to be an underestimated number. Many members expressed that it would be difficult to make the correct decision without this critical information to base their decision on.

The hearing was amicable and the legislation should move forward to a future mark-up.

· March 22, 2017. Dr. Karen Drexler, National Mental Health Director-Addictive Disorders and Dr. Heather Chapman, Director of the Cleveland VA Gambling Treatment Program, briefed the staff of Sen. Warren (MA) on treatments for Gambling Disorders.

9:00 A.M.; Teleconference

POC: (b)(6)

Summary: The office of Sen. Warren is looking to learn about VHA programs or treatments for Veterans who are struggling with gambling addiction. The Senator's office explained that the January 2017 GAO Report MILITARY PERSONNEL DOD and the Coast Guard Need to Screen for Gambling Disorder Addiction and Update Guidance (GAO-117-114) was conducted at their request as they had gotten the requirement inserted in a recent National Defense Authorization Act (NDAA). Seeking to build upon these findings, the Senator's office is seeking to learn more about what programs/treatments that are available to Veterans through VA. Dr. Chapman provided an overview of current services available through VA for Veterans dealing with gambling addiction.

· March 22, 2017. Dr. Peter Almenoff, Senior Advisor to the Secretary and Chief Improvement & Analytics Officer, Veterans Health Administration (VHA) Office of Organizational Excellence, briefed Sen. Bill Cassidy's staff concerning VHA's Strategic Analytics for Improvement and Learning (SAIL) Value Model.

9:30 A.M.; 189 Russell

POC: (b)(6)

Summary: Dr. Almenoff, described the SAIL data web-based balanced scorecard model that VA developed to measure, evaluate and benchmark quality and efficiency at medical centers. He noted that SAIL is an internal benchmark designed to make the VA system better. VA is not a hospital, it is a healthcare delivery system with 75 percent of VA's work outside of a hospital. He provided comparisons and contrasts to similar methods used by Medicare and in the private sector and pointed out that VA has a large outpatient population which the private medical sector does not have. Medicare does not report on access. Other discussions included: the Shreveport VAMC; the difference between SAIL's

internal and external data; HIPAA regulations; mental health measures; VA's crisis hotline.

· March 22, 2017. Joint Hearing of the House and Senate Committee's on Veterans' Affairs to receive the Legislative Presentation of Multiple Veterans Service.

10:00 A.M.; G-50 Dirksen

POC: (b)(6)

Summary: Representatives from the Jewish War Veterans of the United States of America, Fleet Reserve Association, Air Force Sergeants Association, Military Order of the Purple Heart, American Ex-Prisoners of War Organization, Blinded Veterans Association, The Retired Enlisted Association, Military Officers Association of America, and Iraq and Afghanistan Veterans of America testified before a Joint Committee of the House and Senate Committee's on Veterans' Affairs where they provided their organizations' legislative priorities for the year. Overall, the VSOs who testified focused on supporting eliminating the Choice sunset date and ensuring accountability at the VA.

· March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans' Affairs, Subcommittee on Health conducted an oversight hearing on "Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers."

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided tomorrow's summary.

· March 22, 2017. Cheryl Mason, Interim Principal Deputy Vice Chairman, BVA, and Dave McLenachen, Director, Appeals Management Office, met with HVAC DAMA Subcommittee Chairman Bost and HVAC DAMA majority staff in advance of the Subcommittee's Roundtable on Appeals.

2:00 P.M.; 1440 Longworth House Office Building

POCs (b)(6)

Summary: BVA and VBA staff provided a friendly overview and status update for appeals modernization to HVAC DAMA Subcommittee Chairman Bost and HVAC DAMA majority staff. BVA and VBA staff discussed some of the complexities existing in the current process and provided an overview of modernization efforts, including a potential opt-in process for legacy appeals. Chairman Bost asked questions regarding remaining VSO concerns and HVAC DAMA staff discussed IT issues and also asked questions about a proposal to pilot appeals modernization.

· March 22, 2017. Mr. Steven Young, Deputy Under Secretary for Operations Management, briefed Sen. Wyden's staff on the Veterans Crisis Line back-up call center contracts.

4:00 P.M.; 221 Dirksen

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided tomorrow's summary.

· March 22, 2017. Dr. Yehia, Deputy Under Secretary for Health for Community Care, briefed HVAC Majority staff on a TN VA community care cardiology proposal.

5:00 P.M.; Teleconference

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided tomorrow's summary.

Government Accountability Office (GAO) Activity:

Exit Conferences

· March 22, 2017. GAO presented its findings on Graduate Medical Education (GME) Structure and Funding (GAO Code 100504). GAO conducted this review in response to a request by the Chairman of the U.S. House of Representatives Committee on Ways and Means, the Chair of the Republican Conference, and 25 other Members of Congress.

GAO's objective:

Review programs that provide federal funding for GME, including programs funded through the Veterans Health Administration, and report on topics including GME funding, oversight, and the geographic distribution of medical residents.

12:00 P.M.; VACO, Room 532

POC: (b)(6)

Summary: GAO provided a statement of facts (SOF), and VHA provided edits to the statement of facts, prior to the meeting. GAO reviewed the SOF edits and agreed to most VHA edits and others they agreed to take into consideration. VA stated their overall concern with GAO's findings is that it only reflects 2 years of a 10 year program, and it gives the impression that there was only a 20 percent effort from VA toward GME expansion.

GAO stated they anticipate providing their report for comment April 7, 2017, and allowing 30 days to comment. GAO stated they will not be making any recommendations to the Department.

GAO anticipates issuing their final report in Summer 2017.

Look Ahead- Thursday, March 23, 2017

· March 23, 2017. Steve Young, Deputy Under Secretary for Health for Operations and Management, and Matt Eitutis, Acting VHA Member Services Executive Director, will discuss the OIGs Report on the VHA's Veterans Crisis Line with the 4 Corners PSMs and Sen Nelson's staffer.

9:30 A.M.; 334 Cannon

POC: (b)(6)

· March 23, 2017. Ms. Carin Otero, Acting Deputy Assistant Secretary, HR Policy & Planning, HR&A; Ms. Avia Pichon-Cosay, Deputy Associate Chief Officer, HR Operations & Oversight, VHA; Mike Frueh, Chief of Staff, VBA; Ms. Lisa Thomas, Executive Director, Human Capital Management, NCA; and Ms. Rici Mulligan, Executive Director, Budget and Finance, OI&T will brief SVAC Minority staff on "Impact of the Current Hiring Freeze on VA's Exempt and Non-Exempt Vacancies."

11:00 A.M.; Teleconference

POC: (b)(6)

· March 23, 2017. Michael Murphy, Director of VA Northwest Health Network, and Michael J. Kraycinovich, Trial Attorney, Office of the General Counsel, will brief the House Veterans Affairs Committee on the Bremerton, WA CBOC's delays.

1:30 P.M.; 334 Cannon HOB

POC: (b)(6)

· March 23, 2017. (Postponed - March 13, 2017). Dr. Michael S. Icardi, National Director of Pathology and Laboratory Medicine, Dr. Laurence J. Meyer, National Director Genomic Medicine, Chief Officer Specialty Care Services and Ms. Valerie Miller, Associate Program Manager, Pathology and Laboratory Medicine Services will brief Ms. Dahlia Melendrez, SVAC-D, concerning VA blood sources.

2:30 P.M.; Teleconference

POC: (b)(6)

Government Accountability Office (GAO) Activity:

Exit Conferences

· March 23, 2017. GAO is ready to present their findings on Veterans Health Administration (VHA) Information Technology (IT) (GAO Code 100436). GAO conducted this review in response to a request made by former Ranking Member Corrine Brown of the House Committee on Veterans' Affairs (HVAC), and Representative Derek Kilmer. Former HVAC Chairman Jeff Miller was added as a co-requester.

GAO's objectives were to examine:

- The extent to which VHA's current IT systems support the agency's core functions.
- The extent to which VA's IT investment management process ensures that technology investments are prioritized. Selected, executed, and monitored to support VHA's core functions.

11:00 A.M.; VACO, Room 532

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

1:30 P.M.; Room: Cannon 334

POC: (b)(6)

· March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.

- H.R. 467 - The VA Scheduling Accountability Act.
 - H.R. 907 - The Newborn Care Improvement Act.
 - H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
 - H.R. 1005 - To improve the provision of adult day health care services for Veterans.
 - H.R. 1058 - The VA Provider Equity Act.
 - H.R. 1162 - The No Hero Left Untreated Act.
 - H.R. 1545- VA Prescription Data Accountability Act of 2017
 - Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
 - Draft Bill - To prohibit smoking in any VHA facility.
- April 4, 2017. The House Committee on Veterans' Affairs will conduct a hearing on the OIG's Veterans Crisis Line Report.

10:00 A.M.; 334 Cannon

POC: (b)(6)

- April 5, 2017. The HVAC DAMA Subcommittee will hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

10:30 A.M.; Room 334 Cannon HOB

POC: (b)(6)

Agenda

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- HR 1564 (Bergman) Beneficial Travel for VBA (authorization fix)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Brownley

Julia

CA

Meeting

4/4/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

O'Rourke

Beto

TX

Meeting

4/27/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bost

Mike

IL

Meeting

4/27/2017

VA Priorities

To Be Rescheduled from 3/15

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA

State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA

State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA

State Visit Request

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA

Delaware State Veterans Summit

Sen

McCaskill

Claire

MO

Call

3/21/2017

Arla Harrell Act

Sen

Gillibrand

Kirsten

NY

Meeting

3/22/2017

Blue Water Navy

Sen

Sanders

Bernie

VT

Meeting

3/23/2017

Privatization, Choice, Drug Costs

(Meeting in Office of Secretary)

Rep

Mast

Brian

FL

Meeting

4/4/2017

Meet & Greet

Sen

Murray

Patty

WA

Call

3/8/2017

Caregivers

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

Sen

Duckworth

Tammy

IL

Call

3/8/2017

TBD

HVAC Minority Member Retreat

Meeting

(Annapolis)

3/24/2017

SecVA's Way Forward for VA

Rep

McMorris Rogers

Cathy

WA

Meeting

3/24/2017

VA issues and Moving Forward in the 115th

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Sen

Klobuchar

Amy

MN

Call

4/4/2017

Burn Pit Legislation

Rep

Thompson

Mike

CA

Meeting

3/17/2017

Military Veteran Caucus

Sen

Wyden

Ron

OR

Meeting

3/17/2017

VCL Backup Contract

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Wed Mar 22 17:07:50 CDT 2017

Document ID: 0.7.10678.736390-000001

Attachment Name: EAS

Locator: esapst/*:\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5d64882c00: :07005d548e98f2e72572a7bcd10c07eb489bbefc16a56ab01229ce6d0b8a0b8525e5

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) </o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Thursday, March 30, 2017
Date: Wed Mar 29 2017 16:44:23 CDT
Attachments: EAS

All,

Attached is the Morning Report for Thursday, March 30, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Thursday, March 30, 2017

Hot Issues

- None

Emerging

- On March 31, 2017, Ranking Member Walz will visit the Phoenix VAMC to meet with facility's leadership about a recent OIG report Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System and receive demonstrations on VA's scheduling system and Electronic Health Records system.
- On April 10, 2017, Chairman Roe will tour the West LA Campus with the facility's leadership. On the tour Chairman Roe would like to discuss VA's homeless initiatives, the campus's master plan, operations of the VAMC and wants to meet with the Community Veteran Engagement Board.
- On April 11, 2017, Chairman Roe will visit the Phoenix VAMC to meet with facility's leadership about a recent OIG report Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System and receive demonstrations on VA's scheduling system and Electronic Health Records system.

Congressional Letters and Meeting Requests Received

- March 28, 2017. Ranking Member Tim Walz (H-VAC) expressed concern over a Board of Veteran's Appeals disconnected phone line.

- o Received March 29, 2017; VAIQ #7784854

- March 29, 2017. Rep. Rodney Frelinghuysen (R-NJ) expressed concern and support of Community Hope funding for homeless Veterans.

- *Received March 29, 2017; VAIQ #7785012.

- *March, 29, 2017. Chairman Dr. David P. Roe (H-VAC) expressed concern over high tech medical equipment for VHA facilities.

- *Received March 29, 2017; VAIQ #7784998.

Wednesday, March 29, 2017 Events

· March 28, 2017. The HVAC DAMA Subcommittee held a roundtable discussion on the topic of Veteran's Appeals, with a focus on the VA/VSO Appeals Modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion. The Government Accountability Office (GAO) and VSOs will also attend the roundtable.

VA Attendees: BVA Executive in Charge/Acting Vice Chairman David Spickler, BVA Interim Principal Deputy Vice Chairman Cheryl Mason, and VBA Appeals Management Office Director David McLenachen

1:30 P.M.; 334 Cannon

POC: (b)(6)

Summary: BVA and VBA staff provided a detailed path forward for Appeals Modernization, including a discussion on the proposed opt-in process and how it would reduce legacy appeals. GAO discussed strong support for providing a pilot for Appeals Modernization and also expressed concerns related to IT planning and risk mitigation, but agreed that Appeals Modernization is the correct approach. Most VSOs expressed strong support for Appeals Modernization, and for undertaking legislation sooner, rather than after a pilot program. HVAC Chairman Roe, DAMA Chairman Bost, DAMA Ranking Member Etsy, Rep. Titus, and Rep. Bergman were in attendance. DAMA Chairman Bost and Rep. Titus expressed the need for more detailed letters from VA now, as opposed to after potential legislation.

· March 29, 2017. The HVAC Health Subcommittee held a legislative hearing on the agenda set out below. VA witnesses were Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.
- H.R. 467 - The VA Scheduling Accountability Act.
- H.R. 907 - The Newborn Care Improvement Act.
- H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
- H.R. 1005 - To improve the provision of adult day health care services for Veterans.
- H.R. 1162 - The No Hero Left Untreated Act.
- H.R. 1545- VA Prescription Data Accountability Act of 2017
- Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.

· H.R. 1662 Bill - To prohibit smoking in any VHA facility.

Summary: The overall theme of the hearing revolved around mental health and access to health care for women Veterans. Representatives from VFW, DAV, and PVA were present to provide oral testimony. Chairman Roe, arrived late to the hearing and provided a brief statement on his draft medical scribes pilot bill. He stated that while he's disappointed in VA's opposition to the bill, he looks forward to continuing to work with VA on a way forward. Chairman Wenstrup spoke on his bill, H.R. 1662, which would prohibit smoking at VHA facilities and said that he recognizes there are employees and Veterans who are smokers but this legislation provides a delay in implementation and would allow VA to utilize the existing resources to assist Veterans in quitting the habit. He wants to see the money that is currently spent to maintain the smoking facilities to be spent on the health care of Veterans. Ranking Member Brownley provided a brief statement on her two women Veterans-related bills, H.R. 91 and H. R. 95, by stating that we must ensure women Veterans have access to care. She is interested in looking at a VFW proposal that would expand childcare services to homeless Veterans. Chairman Wenstrup was interested in understanding the difference between the Health Advocate Program the VA uses and the pilot program the medical scribes bill mandates VA to do. Dr. Lee provided a brief comparison, noting that at the approximately 14 facilities that HAP is used, the individuals serve a dual role and licensed nurses which are directly employed by VA. Ranking Member Brownley's questions focused on her two bills by asking if VA is looking to expand the retreats for what particular cohorts, to which Dr. Lee stated that we are hoping to expand to all cohorts, including male Veterans, which was also stated in VA's written testimony. The Ranking Member was also curious on how VA received the data that led to VA opposing her childcare bill. Dr. Lee mentioned the Barriers to Care report that was cited in the written testimony and elaborated on some of the methodology for receiving that data. Rep. Takano focused his questions on whether to expand the scope of Rep. Coffman's OTH bill, but asked only the VSOs to opine. DAV and PVA agreed with the legislation as it is, with VFW asking for it to be expanded.

· March 29, 2017. Ron Burke, Assistant Deputy Under Secretary for Field Operations, VBA; and Elizabeth Kruse, Deputy Director for Field Operations, VBA, briefed HVAC staff regarding the non-rating claims backlog.

10:00 A.M.; 335 Cannon

POC: (b)(6)

Summary: VA staff provided a positive briefing to HVAC highlighting the notable decrease in the number of outstanding non-rating claims. The general themes discussed during the briefing include: the 12 new non-rating claims teams; call centers, to include waiting and duration time frames; appeal rates on completed non-rating claims; and quality statistics on completed non-rating claims. HVAC staff raised the topic of appeals and showed particular interest in VBMS and NWQ's capacity to incorporate and manage appeals, and if appeals reform would have any impact. Lastly, HVAC staff expressed an interest in having a quarterly Office of Field Operations/Compensation Service briefing.

· March 29, 2017. Jennifer Harkins, Health Systems Specialist - Executive Assistant to the Medical Center, Director, Jordan W. Benware, Capital Support Consultant, Ben Iachini, Director of Contracting for NCO 4, Joe Maletta, SAO-East Director, Joe Delanko, VISN 4 Capital Asset Manager spoke with George Perez and Eriade Williams, w/Rep. Brady's (PA-1) office regarding update on construction site at CLC collocated with the Philadelphia VAMC.

11:00 A.M.; Teleconference

POC: (b)(6)

Summary: Mr. Delanko provided an update regarding the construction site, informing Mr. Perez of the recent litigation developments concerning the project contractor and the bonding agency due to default of both entities. Mr. Delanko pointed out the default of both entities created a very unique concern/role for the VA which potentially required the additional legal process, however the final litigation allows VA to move forward with the construction project. Mr. Delanko provided the projected way ahead to include, schedule for redesign and bidding as early as Dec 2017 and the beginning of construction o/a FY2018. Mr. Perez had additional questions concerning the award and funding of the design/architect of which Ms. Harkins stated that the funding for design has been obligated in FY17. Lastly, Mr. Perez expressed some additional concerns regarding increased measures and surveillance for pest control, a previous concern from Rep. Brady's office over the past 18 months. Ms. Harkins stated that the Philadelphia VAMC has hired contractors that have increased services and support, however she would report the new concerns to the contracting agency for additional surveillance and would follow-up with Mr. Perez on the status.

· March 29, 2017. Dr. Neil Evans, Chief Officer, Connected Care, briefed staff from Senator Klobuchar's (D-MN) office on the pilot program for the Faster Care for Veterans Act at the Minneapolis VAMC.

12:00 P.M.; Teleconference

POC: (b)(6)

Summary: Staffers initiated the call due to the Minneapolis VAMC's selection as one of three sites for the Pilot Program. The other two sites, Bedford, MA and Salt Lake City, UT were also selected due to Member's interest and sponsorship of the legislation. Staffers biggest concern was whether the VAMC would have to fund the program directly and if that would have any effect on patient care. Dr. Evans explained that the program was being funded by Choice and the VAMC would not have to put forth any of their own money. Dr. Evans gave a general overview of the pilot and where VA was in the process. Staffers were hoping to get information on formal announcements and timelines, but it was explained that most of that would not be known until the contract was awarded on April 15th. Dr. Evans explained some of the specifications and requirements that VA expected and was laid out in the RFP. The Senator's will request a follow-up meeting when the contract is awarded.

· March 29, 2017. Rep. Tim Ryan (D-13-OH) requested an in-person meeting with Dr. Tracy Gaudet, Director of the Office of Patient Centered Care. According to the Congressman's staff, Rep. T. Ryan is personal friends with Dr. Gaudet and wanted an update to the projects she has been working on. Dr. Benjamin Kligler, Director of Integrated Health Coordinator Center accompanied Dr. Gaudet to the meeting.

12:30 P.M.; 1126 Longworth HOB

POC: (b)(6)

Summary: The conversation mainly centered on the integrated healthcare model both Dr. Gaudet and Dr. Kligler have been developing. The model focuses on connecting Veterans with a trained peer, who is a fellow Veteran. This peer would help the Veteran identify their health goals. Depending on the Veteran's health goals, they can connect with wellness programs that can help the Veteran achieve those goals through "self-health"; e.g. if the health goal is to lose weight, a Veteran would work with a nutrition expert on their dietary goals. Limited programs currently exist at different VHA facilities. However, fully funded programs are slated to begin at 18 sites in October of FY18. Rep. Ryan was very

interested in the subject matter and asked both Dr. Gaudet and Dr. Kligler to appear as witnesses for a, yet unscheduled, MilCon VA Appropriations Hearing. Rep. Ryan also pulled HVAC Health Subcommittee Chairman, Mr. Wenstrup, into the room and he was also very interested in what our VA doctors had to say about integrated health.

· March 29, 2017. Willie Clark, Deputy Under Secretary for Field Operations, VBA; and Ronald Burke, Assistant Deputy Under Secretary for Field Operations, VBA, briefed HVAC and SVAC staff regarding mandatory overtime.

2:30 P.M.; Teleconference

POCs: (b)(6)

Summary: The purpose of this call was to notify 4-Corners staff that VBA intends on extending strategic mandatory overtime for an additional 30 days. 4-Corners staff inquired if the agreement VBA made with AFGE was on a national or local basis; how many more months VA anticipates utilizing mandatory overtime; how many RVSRs are currently working overtime; and if VA will consider mandatory overtime for VSRs in the future.

· March 29, 2017. Dr. Steven Lieberman, ADUSH for Access to Care, Dr. Mark Shelhorse, Acting VISN 6 Director, Dr. Kameron Matthews, Deputy Executive Director, Provider Relations and Services, Office of Community Care, Dr. Michael Davies, Senior Medical Advisor, Office of Veterans Access to Care and Andy Bartlett, Health System Specialist briefed Members of the House of Representatives with the NC Delegation on the VISN 6 OIG Report.

2:30 P.M.; H-107 Capitol

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

Look Ahead- Thursday, March 30, 2017

· March 30, 2017. Dr. Kathleen Klink, Chief, Health Professions Education, Office of Acad. Affiliations, VHA will provide an update on VHA's Graduate Medical Education Program to Rep. Mark Takano.

10:30 A.M.; 1507 Longworth

POC: (b)(6)

Government Accountability Office (GAO) Activity:

Exit Conferences

· March 30, 2017. GAO is ready to present its findings on VA Treatment of Gulf War Illness Claims (GAO Job Code 100365). GAO conducted this review in response to a request by the Chair of the Subcommittee on Investigations and Oversight, Committee on Veterans' Affairs, U.S. House of Representatives.

GAO Objective:

- What have been the trends in the disability claims related to Gulf War Illness;
- What policies and procedure does VA have in place to ensure accurate and timely processing of these claims; and
- To what extent is VA using prevailing research and science to inform their disability decisions for Gulf War Illness, including their designation of symptoms and conditions as presumptively linked to Gulf War service.

1:00 P.M.; 1800 G Street, NW, Room 436F

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· April 4, 2017. The House Committee on Veterans' Affairs will conduct a hearing on the OIG's Veterans Crisis Line Report.

10:00 A.M.; 334 Cannon

POC: (b)(6)

· April 4, 2017. The Subcommittee on Economic Opportunity of the House Committee on Veterans' Affairs will conduct an oversight hearing on "Assessing VA Approved Appraisers and How to Improve the Program for the 21st Century." VA witnesses have not been established.

2:00 P.M.; 334 Cannon

POC: (b)(6)

· April 5, 2017. The HVAC DAMA Subcommittee will hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

10:30 A.M.; Room 334 Cannon HOB

POC: (b)(6)

Agenda

- HR 1328 (Bost)-Auto COLA
 - HR 1329 (Bost)-Annual COLA
 - HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
 - HR 1564 (Bergman) Beneficial Travel for VBA (authorization fix)
 - HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
 - Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
 - HR 299 (Valadao) Blue Water Navy
-
- April 5, 2017. The HVAC Health Subcommittee intends to hold a markup on various legislation.

2:00 P.M.; 334 Cannon

POC: (b)(6)

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA Delaware State Veterans Summit

Sen

Klobuchar

Amy

MN

Call

4/4/2017

Burn Pit Legislation

Rep

Bost

Mike

IL

Meeting

4/4/2017

Appeals Reform Legislation

Sen

Murray

Patty

WA

Meeting

3/8/2017

4/6/2017

Caregivers

Sen

Duckworth

Tammy

IL

Meeting

3/8/2017

4/6/2017

Choice??

Sen

Wyden

Ron

OR

Meeting

3/17/2017

4/6/2017

VCL Backup Contract

Sen

Enzi

Michael

WY

Meeting

3/21/2017

4/6/2017

Choice

Sen

Sanders

Bernie

VT

Meeting

3/6/2017

4/6/2017

Privatization, Choice Reschedule from 3/23

Rep

O'Rourke

Beto

TX

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

HVAC Minority Member Retreat

Meeting

5/1/2017

VA Priorities - Armed Forces Retirement Home (Washington, DC)

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Rep

Brownley

Julia

CA

Meeting

3/28/2017

VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Young

David

IA

Meeting

3/23/2017

VCL

Rep

Roe

Phil

TN

Call

3/29/2017

Cardiology Contract

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Wed Mar 29 16:44:23 CDT 2017

Document ID: 0.7.10678.739419-000001

Attachment Name: EAS

Locator: esapst/*:\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5dc4592c00: :0700922728317c6f082e24ea44ccdee68bfee46e0687b15f0bbde8d01c702369876a

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) /o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)
To:
Cc:
Bcc:
Subject: Morning Report: Tuesday, March 28, 2017
Date: Mon Mar 27 2017 16:21:23 CDT
Attachments: EAS

All,

Attached is the Morning Report for Tuesday, March 28, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Tuesday, March 28, 2017

Hot Issues

- None

Emerging

- None

Congressional Letters and Meeting Requests Received

- None

Monday, March 27, 2017 Events

- March 24, 2017. BVA Acting Vice Chairman Executive in Charge David Spickler, Interim Principal Deputy Vice Chairman Cheryl Mason, Chief Counsel for Policy & Procedure Veterans Administration Donnie Hachey, Chief Counsel for Policy & Procedure, Veterans Administration James Ridgway, VBA Director, Appeals Management Office David McLenachen, and VACI Director Office of Enterprise Integration Patrick Littlefield briefed 4-Corners staff on recent developments related to Appeals Modernization.

3:00 P.M.; Teleconference

POC: (b)(6)

Summary: VA staff provided an informational briefing to 4-Corners staff on Appeals Modernization and recent developments to reduce legacy appeals within the new proposed system. BVA and VBA staff provided a detailed overview of the proposed opt-in process and also discussed recommendations for Appeals Modernization outlined in the recent GAO report. HVAC and SVAC staff asked questions regarding potential resource needs, buy-in from the VSO community, and also points in the appeals process where opt-in could occur.

- March 27, 2017. Danny Devine, Deputy Director of Policy and Procedures, Compensation Service, VBA, and Laurine Carson, Assistant Director for Procedures, Compensation Service, VBA, briefed SVAC staff regarding VA's efforts to update the disability rating schedule.

1:00 P.M.; Teleconference

POC: (b)(6)

Summary: VBA staff provided a friendly overview and update to SVAC majority and minority staff on VA's efforts to update the disability rating schedule. SVAC staff inquired if the personnel assigned to the rating schedule working group, to include medical officers, would stay intact after the disability rating schedule was updated, and which VA office would manage the roll-out of the new disability rating schedule. SVAC staff also expressed an interest in whether medical or economic data is shaping the updated rating schedule, and in the cost of an "earnings lost" study for VA.

· March 27, 2017. BVA Executive in Charge/Acting Vice Chairman, Dave Spickler and VBA Appeals Management Office Director, David McLenachen, briefed SVAC minority staff on Appeals Modernization and the proposed appeals pilot program.

2:00 P.M.; 311 Hart

POC: (b)(6)

Summary: BVA and VBA staff held a friendly briefing on the status of Appeals Modernization efforts with SVAC minority staff. VA staff provided background information on appeals inventory, discussed the recent opt-in proposal, and also GAO recommendations including holding an appeals pilot. SVAC minority staff asked questions regarding buy-in from VSOs for the opt-in proposal, and also briefly discussed an Appeals Modernization bill introduced by Senator Blumenthal last week.

Look Ahead- Tuesday, March 28, 2017

· March 28, 2017. Rep. Tim Ryan (D-13-OH) requested an in person meeting with Dr. Tracy Gaudet, Director of the Office of Patient Centered Care. According to the Congressman's staff, Rep. T. Ryan is personal friends with Dr. Gaudet and wants an update to the projects she has been working on. Dr. Benjamin Kligler, Director of Integrated Health Coordinator Center will accompany Dr. Gaudet to the meeting.

12:30 P.M.; 1126 Longworth HOB

POC: (b)(6)

· March 28, 2017. VA's Office of Tribal Government Relations (OTGR) will meet with Majority and Minority staffers on the Senate Veterans' Affairs and Senate Indian Affairs Committees. The purpose of the meet and greet is to introduce OTGR's front line staff, Field Tribal Government Relations Specialists, to Committee staffers who work on tribal Veterans issues and hear from the staffers about the Committees' priorities as they relate to American Indian and Alaska Native Veterans.

1:00 P.M.; 418 Russell

POC: (b)(6)

· March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO Appeals Modernization proposal. The Subcommittee

requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

1:30 P.M.; 334 Cannon

POC: (b)(6)

· March 28, 2017. Dr. Jennifer Lee, Deputy Under Secretary for Health for Policy and Services and Dr. Joel Scholten, National Director, Physical Medicine and Rehabilitation will brief Representative Sessions office regarding hyperbaric oxygen therapy. This is a follow up to last week's meeting on March 21st.

2:00 P.M.; 2233 Rayburn

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.
- H.R. 467 - The VA Scheduling Accountability Act.
- H.R. 907 - The Newborn Care Improvement Act.
- H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
- H.R. 1005 - To improve the provision of adult day health care services for Veterans.
- H.R. 1162 - The No Hero Left Untreated Act.
- H.R. 1545- VA Prescription Data Accountability Act of 2017
- Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
- H.R. 1662 Bill - To prohibit smoking in any VHA facility.

- April 4, 2017. The House Committee on Veterans' Affairs will conduct a hearing on the OIG's Veterans Crisis Line Report.

10:00 A.M.; 334 Cannon

POC: (b)(6)

- April 4, 2017. The Subcommittee on Economic Opportunity of the House Committee on Veterans' Affairs will conduct an oversight hearing on "Assessing VA Approved Appraisers and How to Improve the Program for the 21st Century." VA witnesses have not been established.

2:00 P.M.; 334 Cannon

POC: (b)(6)

- April 5, 2017. The HVAC DAMA Subcommittee will hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

10:30 A.M.; Room 334 Cannon HOB

POC: (b)(6)

Agenda

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- HR 1564 (Bergman) Beneficial Travel for VBA (authorization fix)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Sen

McCain

John

AZ

Call

3/29/2017

Choice

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA Delaware State Veterans Summit

Sen

Klobuchar

Amy

MN

Call

4/4/2017

Burn Pit Legislation

Rep

Brownley

Julia

CA

Meeting

4/4/2017

VA Priorities Rescheduled from 3/15

Rep

Bost

Mike

IL

Meeting

4/4/2017

Appeals Reform Legislation

Sen

Murray

Patty

WA

Meeting

4/6/2017

Caregivers

Sen

Duckworth

Tammy

IL

Meeting

4/6/2017

Choice??

Sen

Wyden

Ron

OR

Meeting

4/6/2017

VCL Backup Contract

Sen

Enzi

Michael

WY

Meeting

4/6/2017

Choice

Rep

O'Rourke

Beto

TX

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

HVAC Minority Member Retreat

Meeting

5/1/2017

VA Priorities - Armed Forces Retirement Home (Washington, DC)

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Sanders

Bernie

VT

Meeting

3/6/2017

Privatization, Choice Reschedule from 3/23

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Young

David

IA

Meeting

3/23/2017

VCL

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Mon Mar 27 16:21:23 CDT 2017

Document ID: 0.7.10678.738593-000001

Attachment Name: EAS

Locator: esapst/*:\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5dc46b2c00: :0700aa0c7fe42ff46c560cab3d2f1a2121478467cbfb25d4e4f665ef793b626ebf42

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) </o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Wednesday, March 29, 2017
Date: Tue Mar 28 2017 16:25:28 CDT
Attachments: EAS

All,

Attached is the Morning Report for Wednesday, March 29, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Wednesday, March 29, 2017

Hot Issues

- None

Emerging

- On March 31, 2017, Ranking Member Walz will visit the Phoenix VAMC to meet with facility's leadership about a recent OIG report Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System and receive demonstrations on VA's scheduling system and Electronic Health Records system.
- On April 10, 2017, Chairman Roe will tour the West LA Campus with the facility's leadership. On the tour Chairman Roe would like to discuss VA's homeless initiatives, the campus's master plan, operations of the VAMC and wants to meet with the Community Veteran Engagement Board.
- On April 11, 2017, Chairman Roe will visit the Phoenix VAMC to meet with facility's leadership about a recent OIG report Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System and receive demonstrations on VA's scheduling system and Electronic Health Records system.

Congressional Letters and Meeting Requests Received

- March 29, 2017. Rep. Tom Emmer (R-MN) expressed concern over a disconnected Board of Veteran's Appeal phone line.

*Received March 28, 2017; VAIQ #7784741.

*March, 28, 2017. 80 Members of Congress expressed concern over the Veterans Crisis Line (VCL).

*Received March 28, 2017; VAIQ #7784735.

Tuesday, March 28, 2017 Events

- March 28, 2017. Mr. Kevin Friel, Assistant Director, Pension & Fiduciary Service, VBA and Kimberly Wright, Executive Director, Office of Field Programs NCA briefed Congressman Issa's (CA-49) Staff on Veterans Burial Benefits.

10:30 A.M.; Teleconference

POC: (b)(6)

Summary: This was a short call; Todd Putnam, Congressman Issa's Defense Legislative Fellow took the briefing. Todd relayed that the Congressman is interested in proposing legislation to effectively expand Veteran current programs to help with Veteran burial benefits. Mr. Friel and Mrs. Wright explained the processes of current programs that cover and reimburse for most burial expenses incurred for homeless Veterans and their families to help finance the costs of transportation and funerals for the Veterans remains. The discussion was well received. The staffer was very appreciative.

· March 28, 2017. VA's Office of Tribal Government Relations (OTGR) met with Majority and Minority staffers on the Senate Veterans' Affairs and Senate Indian Affairs Committees. The purpose of the meet and greet was to introduce OTGR's front line staff, Field Tribal Government Relations Specialists, to Committee staffers who work on tribal Veterans issues and hear from the staffers about the Committees' priorities as they relate to American Indian and Alaska Native Veterans.

1:00 P.M.; 418 Russell

POC: (b)(6)

Summary: Ms. Stephanie Birdwell, Director, Office of Tribal Government Relations (OTGR), Mr. Clay Ward, OTGR and their colleagues, Ms. Terry Bentley (Northwest), Ms. Mary Culley (Southern Plains), Ms. Homana Pawiki (Southwest) and Mr. Peter Vicaire (Northern Plains) – all Tribal Government Relations Specialists who work in the field - met with SVAC and SIAC staffers. Ms. Birdwell gave a quick overview of OTGR and its role highlighting key the top five priorities identified by Tribal Governments: access to health care, housing and homelessness, PTSD and mental health services, understanding Veterans benefits and benefits for families and transportation. Ms. Birdwell also stressed the importance of respectful Government to Government relations and outreach that encompasses cultural sensitivity and an awareness of the customer base. The Specialists shared examples from their particular regions describing their experiences relative to choice, copays, tribal health programs, and the Native American Direct Loan Program in VBA. One staffer mentioned that SIAC is planning a hearing in May on Housing and Homelessness in Indian Country. VA likely will be invited to participate.

· March 28, 2017. The HVAC DAMA Subcommittee held a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion.

VA Attendees: BVA Executive in Charge/Acting Vice Chairman David Spickler, BVA Interim Principal Deputy Vice Chairman Cheryl Mason, and VBA Appeals Management Office Director David McLenachen

1:30 P.M.; 334 Cannon

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

· March 28, 2017. Dr. Jennifer Lee, Deputy Under Secretary for Health for Policy and Services

and Dr. Joel Scholten, National Director, Physical Medicine and Rehabilitation briefed Rep. Sessions's office regarding hyperbaric oxygen therapy. This was a follow up to last week's meeting on March 21st.

2:00 P.M.; 2233 Rayburn

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

Look Ahead- Wednesday, March 29, 2017

· March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.
- H.R. 467 - The VA Scheduling Accountability Act.
- H.R. 907 - The Newborn Care Improvement Act.
- H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
- H.R. 1005 - To improve the provision of adult day health care services for Veterans.
- H.R. 1162 - The No Hero Left Untreated Act.
- H.R. 1545- VA Prescription Data Accountability Act of 2017
- Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
- H.R. 1662 Bill - To prohibit smoking in any VHA facility.

· March 29, 2017. Ron Burke, Assistant Deputy Under Secretary for Field Operations, VBA; and Elizabeth Kruse, Deputy Director for Field Operations, VBA, will provide a briefing to HVAC staff regarding the non-rating claims backlog.

10:00 A.M.; 335 Cannon

POC: (b)(6)

· March 29, 2017. Jennifer Harkins, Health Systems Specialist - Executive Assistant to the Medical Center, Director, Jordan W. Benware, Capital Support Consultant, Ben Iachini, Director of Contracting for NCO 4, Joe Maletta, SAO-East Director, Joe Delanko, VISN 4 Capital Asset Manager will speak with George Perez and Eriade Williams, w/Rep. Brady's (PA-1) office regarding update on construction site at CLC collocated with the Philadelphia VAMC.

11:00 A.M.; Teleconference

POC: (b)(6)

· March 29, 2017. Rep. Tim Ryan (D-13-OH) requested an in person meeting with Dr. Tracy Gaudet, Director of the Office of Patient Centered Care. According to the Congressman's staff, Rep. T. Ryan is personal friends with Dr. Gaudet and wants an update to the projects she has been working on. Dr. Benjamin Kligler, Director of Integrated Health Coordinator Center will accompany Dr. Gaudet to the meeting.

12:30 P.M.; 1126 Longworth HOB

POC: (b)(6)

· March 29, 2017. Willie Clark, Deputy Under Secretary for Field Operations, VBA; and Ronald Burke, Assistant Deputy Under Secretary for Field Operations, VBA, will provide a briefing to HVAC and SVAC staff regarding mandatory overtime.

2:30 P.M.; Teleconference

POCs: (b)(6)

· March 29, 2017. Dr. Steven Lieberman, ADUSH for Access to Care, Dr. Mark Shelhorse, Acting VISN 6 Director, Dr. Kameron Matthews, Deputy Executive Director, Provider Relations and Services, Office of Community Care, Dr. Michael Davies, Senior Medical Advisor, Office of Veterans Access to Care and Andy Bartlett, Health System Specialist will provide Members of the House of Representatives with the NC Delegation a briefing on the VISN 6 OIG Report.

2:30 P.M.; H-107 Capitol

POC: (b)(6)

· March 29, 2017. Willie Clark, Deputy Under Secretary for Field Operations, VBA; and Ronald Burke, Assistant Deputy Under Secretary for Field Operations, VBA, will provide a briefing to HVAC and SVAC staff regarding mandatory overtime.

2:30 P.M.; Teleconference

POCs: (b)(6)

Upcoming Hearings and Testimony Due to Congress

- April 4, 2017. The House Committee on Veterans' Affairs will conduct a hearing on the OIG's Veterans Crisis Line Report.

10:00 A.M.; 334 Cannon

POC: (b)(6)

- April 4, 2017. The Subcommittee on Economic Opportunity of the House Committee on Veterans' Affairs will conduct an oversight hearing on "Assessing VA Approved Appraisers and How to Improve the Program for the 21st Century." VA witnesses have not been established.

2:00 P.M.; 334 Cannon

POC: (b)(6)

- April 5, 2017. The HVAC DAMA Subcommittee will hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

10:30 A.M.; Room 334 Cannon HOB

POC: (b)(6)

Agenda

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- HR 1564 (Bergman) Beneficial Travel for VBA (authorization fix)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

- April 5, 2017. The HVAC Health Subcommittee intends to hold a markup on various legislation.

2:00 P.M.; 334 Cannon

POC: (b)(6)

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Sen

McCain

John

AZ

Call

3/29/2017

Choice Senator did not keep scheduled 3/23 call

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA Delaware State Veterans Summit

Sen

Klobuchar

Amy

MN

Call

4/4/2017

Burn Pit Legislation

Rep

Bost

Mike

IL

Meeting

4/4/2017

Appeals Reform Legislation

Sen

Murray

Patty

WA

Meeting

4/6/2017

Caregivers

Sen

Duckworth

Tammy

IL

Meeting

4/6/2017

Choice??

Sen

Wyden

Ron

OR

Meeting

4/6/2017

VCL Backup Contract

Sen

Enzi

Michael

WY

Meeting

4/6/2017

Choice

Sen

Sanders

Bernie

VT

Meeting

4/6/2017

Privatization, Choice Reschedule from 3/23

Rep

O'Rourke

Beto

TX

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

HVAC Minority Member Retreat

Meeting

5/1/2017

VA Priorities - Armed Forces Retirement Home (Washington, DC)

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Rep

Brownley

Julia

CA

Meeting

3/28/2017

VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Young

David

IA

Meeting

3/23/2017

VCL

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Tue Mar 28 16:25:28 CDT 2017

Document ID: 0.7.10678.739058-000001

Attachment Name: EAS

Locator: esapst/*:\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5d44632c00: :07004201d90f732d0987e9ae2a3c794aa4b92a0c9657cf3a3569acb57f4fc6543023

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b)(6)>
To: DJS </o=va/ou=exchange administrative
group (fydibohf23spdlt)/cn=recipients/cn=(b)(6)>
Cc:
Bcc:
Subject: FW: Morning Report: Wednesday, March 29, 2017
Date: Tue Mar 28 2017 20:42:48 CDT
Attachments: EAS

See the HVAC touring the facilities

Sent with Good (www.good.com)

-----Original Message-----

From: (b)(6)
Sent: Tuesday, March 28, 2017 05:25 PM Eastern Standard Time
To:
Subject: Morning Report: Wednesday, March 29, 2017

All,

Attached is the Morning Report for Wednesday, March 29, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Wednesday, March 29, 2017

Hot Issues

- None

Emerging

- On March 31, 2017, Ranking Member Walz will visit the Phoenix VAMC to meet with facility's leadership about a recent OIG report Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System and receive demonstrations on VA's scheduling system and Electronic Health Records system.
- On April 10, 2017, Chairman Roe will tour the West LA Campus with the facility's leadership. On the tour Chairman Roe would like to discuss VA's homeless initiatives, the campus's master plan, operations of the VAMC and wants to meet with the Community Veteran Engagement Board.
- On April 11, 2017, Chairman Roe will visit the Phoenix VAMC to meet with facility's leadership about a recent OIG report Review of Alleged Consult Mismanagement at the Phoenix VA Health Care System and receive demonstrations on VA's scheduling system and Electronic Health Records system.

Congressional Letters and Meeting Requests Received

- March 29, 2017. Rep. Tom Emmer (R-MN) expressed concern over a disconnected Board of Veteran's Appeal phone line.

*Received March 28, 2017; VAIQ #7784741.

*March, 28, 2017. 80 Members of Congress expressed concern over the Veterans Crisis Line (VCL).
*

*Received March 28, 2017; VAIQ #7784735.

Tuesday, March 28, 2017 Events

· March 28, 2017. Mr. Kevin Friel, Assistant Director, Pension & Fiduciary Service, VBA and Kimberly Wright, Executive Director, Office of Field Programs NCA briefed Congressman Issa's (CA-49) Staff on Veterans Burial Benefits.

10:30 A.M.; Teleconference

POC: (b)(6)

Summary: This was a short call; Todd Putnam, Congressman Issa's Defense Legislative Fellow took the briefing. Todd relayed that the Congressman is interested in proposing legislation to effectively expand Veteran current programs to help with Veteran burial benefits. Mr. Friel and Mrs. Wright explained the processes of current programs that cover and reimburse for most burial expenses incurred for homeless Veterans and their families to help finance the costs of transportation and funerals for the Veterans remains. The discussion was well received. The staffer was very appreciative.

· March 28, 2017. VA's Office of Tribal Government Relations (OTGR) met with Majority and Minority staffers on the Senate Veterans' Affairs and Senate Indian Affairs Committees. The purpose of the meet and greet was to introduce OTGR's front line staff, Field Tribal Government Relations Specialists, to Committee staffers who work on tribal Veterans issues and hear from the staffers about the Committees' priorities as they relate to American Indian and Alaska Native Veterans.

1:00 P.M.; 418 Russell

POC: (b)(6)

Summary: Ms. Stephanie Birdwell, Director, Office of Tribal Government Relations (OTGR), Mr. Clay Ward, OTGR and their colleagues, Ms. Terry Bentley (Northwest), Ms. Mary Culley (Southern Plains), Ms. Homana Pawiki (Southwest) and Mr. Peter Vicaire (Northern Plains) – all Tribal Government Relations Specialists who work in the field - met with SVAC and SIAC staffers. Ms. Birdwell gave a quick overview of OTGR and its role highlighting key the top five priorities identified by Tribal Governments: access to health care, housing and homelessness, PTSD and mental health services, understanding Veterans benefits and benefits for families and transportation. Ms. Birdwell also stressed the importance of respectful Government to Government relations and outreach that encompasses cultural sensitivity and an awareness of the customer base. The Specialists shared examples from their particular regions describing their experiences relative to choice, copays, tribal health programs, and the Native American Direct Loan Program in VBA. One staffer mentioned that SIAC is planning a hearing in May on Housing and Homelessness in Indian Country. VA likely will be invited to participate.

· March 28, 2017. The HVAC DAMA Subcommittee held a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion.

VA Attendees: BVA Executive in Charge/Acting Vice Chairman David Spickler, BVA Interim Principal Deputy Vice Chairman Cheryl Mason, and VBA Appeals Management Office Director David McLenachen

1:30 P.M.; 334 Cannon

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

· March 28, 2017. Dr. Jennifer Lee, Deputy Under Secretary for Health for Policy and Services and Dr. Joel Scholten, National Director, Physical Medicine and Rehabilitation briefed Rep. Sessions's office regarding hyperbaric oxygen therapy. This was a follow up to last week's meeting on March 21st.

2:00 P.M.; 2233 Rayburn

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

Look Ahead- Wednesday, March 29, 2017

· March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.
- H.R. 467 - The VA Scheduling Accountability Act.
- H.R. 907 - The Newborn Care Improvement Act.
- H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
- H.R. 1005 - To improve the provision of adult day health care services for Veterans.
- H.R. 1162 - The No Hero Left Untreated Act.

- H.R. 1545- VA Prescription Data Accountability Act of 2017
- Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
- H.R. 1662 Bill - To prohibit smoking in any VHA facility.

· March 29, 2017. Ron Burke, Assistant Deputy Under Secretary for Field Operations, VBA; and Elizabeth Kruse, Deputy Director for Field Operations, VBA, will provide a briefing to HVAC staff regarding the non-rating claims backlog.

10:00 A.M.; 335 Cannon

POC: (b)(6)

· March 29, 2017. Jennifer Harkins, Health Systems Specialist - Executive Assistant to the Medical Center, Director, Jordan W. Benware, Capital Support Consultant, Ben Iachini, Director of Contracting for NCO 4, Joe Maletta, SAO-East Director, Joe Delanko, VISN 4 Capital Asset Manager will speak with George Perez and Eriade Williams, w/Rep. Brady's (PA-1) office regarding update on construction site at CLC collocated with the Philadelphia VAMC.

11:00 A.M.; Teleconference

POC: (b)(6)

· March 29, 2017. Rep. Tim Ryan (D-13-OH) requested an in person meeting with Dr. Tracy Gaudet, Director of the Office of Patient Centered Care. According to the Congressman's staff, Rep. T. Ryan is personal friends with Dr. Gaudet and wants an update to the projects she has been working on. Dr. Benjamin Kligler, Director of Integrated Health Coordinator Center will accompany Dr. Gaudet to the meeting.

12:30 P.M.; 1126 Longworth HOB

POC: (b)(6)

· March 29, 2017. Willie Clark, Deputy Under Secretary for Field Operations, VBA; and Ronald Burke, Assistant Deputy Under Secretary for Field Operations, VBA, will provide a briefing to HVAC and SVAC staff regarding mandatory overtime.

2:30 P.M.; Teleconference

POCs: (b)(6)

· March 29, 2017. Dr. Steven Lieberman, ADUSH for Access to Care, Dr. Mark Shelhorse, Acting VISN 6 Director, Dr. Kameron Matthews, Deputy Executive Director, Provider Relations and Services, Office of Community Care, Dr. Michael Davies, Senior Medical Advisor, Office of Veterans Access to

Care and Andy Bartlett, Health System Specialist will provide Members of the House of Representatives with the NC Delegation a briefing on the VISN 6 OIG Report.

2:30 P.M.; H-107 Capitol

POC: (b)(6)

· March 29, 2017. Willie Clark, Deputy Under Secretary for Field Operations, VBA; and Ronald Burke, Assistant Deputy Under Secretary for Field Operations, VBA, will provide a briefing to HVAC and SVAC staff regarding mandatory overtime.

2:30 P.M.; Teleconference

POCs: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· April 4, 2017. The House Committee on Veterans' Affairs will conduct a hearing on the OIG's Veterans Crisis Line Report.

10:00 A.M.; 334 Cannon

POC: (b)(6)

· April 4, 2017. The Subcommittee on Economic Opportunity of the House Committee on Veterans' Affairs will conduct an oversight hearing on "Assessing VA Approved Appraisers and How to Improve the Program for the 21st Century." VA witnesses have not been established.

2:00 P.M.; 334 Cannon

POC: (b)(6)

· April 5, 2017. The HVAC DAMA Subcommittee will hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

10:30 A.M.; Room 334 Cannon HOB

POC: (b)(6)

Agenda

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA

- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
 - HR 1564 (Bergman) Beneficial Travel for VBA (authorization fix)
 - HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
 - Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
 - HR 299 (Valadao) Blue Water Navy
-
- April 5, 2017. The HVAC Health Subcommittee intends to hold a markup on various legislation.

2:00 P.M.; 334 Cannon

POC: (b)(6)

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Sen

McCain

John

AZ

Call

3/29/2017

Choice Senator did not keep scheduled 3/23 call

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA Delaware State Veterans Summit

Sen

Klobuchar

Amy

MN

Call

4/4/2017

Burn Pit Legislation

Rep

Bost

Mike

IL

Meeting

4/4/2017

Appeals Reform Legislation

Sen

Murray

Patty

WA

Meeting

4/6/2017

Caregivers

Sen

Duckworth

Tammy

IL

Meeting

4/6/2017

Choice??

Sen

Wyden

Ron

OR

Meeting

4/6/2017

VCL Backup Contract

Sen

Enzi

Michael

WY

Meeting

4/6/2017

Choice

Sen

Sanders

Bernie

VT

Meeting

4/6/2017

Privatization, Choice Reschedule from 3/23

Rep

O'Rourke

Beto

TX

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

HVAC Minority Member Retreat

Meeting

5/1/2017

VA Priorities - Armed Forces Retirement Home (Washington, DC)

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Rep

Brownley

Julia

CA

Meeting

3/28/2017

VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Young

David

IA

Meeting

3/23/2017

VCL

Owner: (b)(6) M.D. </o=va/ou=exchange administrative group (fydibohf23spdlit)
/cn=recipients/cn=(b)(6)>
Filename: EAS
Last Modified: Tue Mar 28 20:42:48 CDT 2017

Document ID: 0.7.10678.739102-000001

Attachment Name: EAS

Locator: esapst/*:\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5da4612c00: :0700b557d4785d8df2aa4904735f74b0c4e7c64cdd3dd145dce1274ec27caf2b548f

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6)/o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6) >
To:
Cc:
Bcc:
Subject: Morning Report: Monday, March 27, 2017
Date: Fri Mar 24 2017 16:24:29 CDT
Attachments: EAS

All,

Attached is the Morning Report for Monday, March 27, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Monday, March 27, 2017

Hot Issues

- None

Emerging

- None

Congressional Letters and Meeting Requests Received

- March 23, 2017. Sen. Tom Udall (D-NM) expressed concern over VA staffing shortage, and mental health care services in New Mexico.
 - o Received March 24, 2017: VAIQ #7784042

Friday, March 24, 2017 Events

- March 23, 2017. Dr. Baligh Yehia, Deputy Under Secretary for Health for Community Care, held a discussion with Sen Enzi's staff on provider payments in Wyoming following up with the Secretary's letter to the Senator.

5:00 P.M.; Teleconference

POC: (b)(6)

Summary: Prior to Dr. Yehia providing an update, he gave Sen Enzi's staffer an opportunity to discuss their office's concerns. The staffer informed him that a lot of the casework has been resolved but in the last 6-8 months the Veterans in WY have had an increase in VA Choice appointments. She went on to discuss how several of their providers are experiencing challenges in getting payments for their services to Veterans. Dr. Baligh acknowledged the challenges that many of the providers across the country are experiencing. He went on to discuss the complexity of Choice and the importance of education, customer service and good provider relations. Then he mentioned the importance of the extension for VCP and the few fixes to include VA being the primary coordinator of benefits, which will result in timelier provider payments. Dr. Yehia also mentioned the billing fact sheet which was shared with Sen Enzi's staffer following the conference call. The fact sheet is a tool to assist community providers in submitting claims and getting paid faster. Finally, he offered to do a follow-up face to face meeting with the staffer and a senior representative from Health Net accompanying him in order to further discuss provider payment issues in WY. He also promised to bring a monthly snapshot by VAMC showing the current status of claims in WY to that face to face meeting.

March 24, 2017. Mr. Jim Warner, Chief Learning Officer, EES; Dr. Yasuharu Okuda, SimLEARN Medical Director; and Dr. Harry Robinson, SimLEARN Project Manager, briefed Congresswoman Stephanie Murphy (D-FL-07) on VA's SimLEARN program.

11:30 A.M.; 1237 Longworth

POC: (b)(6)

Summary: Dr. Okuda and Dr. Robinson provided the Congresswoman with an overview of VA's SimLEARN facility, which is located in her district. Dr. Okuda spoke about the simulation based training and how useful it is for experienced personnel, versus the private sector where simulation is geared towards students. The Congresswoman was impressed with the state of the art technology and curious about the training requirements and hours that VA personnel would train at SimLEARN. Dr. Okuda explained how VA does required training versus elective training and how that would be spread out in the field and at SimLEARN. He added that the advantages the facility provides will greatly reduce the burden on frontline doctors and nurses at VA. He used the example that simulation training allows VA staff to evaluate potential dangers when opening a new facility, or use a 3D printer to create a human organ for difficult, pre-operation surgery training. Mr. Warner emphasized the role that the SimLEARN facility has in the potential for future opportunities in developing new training strategies and the potential impact it could have on healthcare at a national scale. Dr. Robinson spoke about the strong partnership the facility has with DoD and the University of Central Florida. The Congresswoman was very appreciative of the briefing and would like to visit the facility sometime in the coming weeks.

March 24, 2017. Dr. Yehia, Deputy Under Secretary for Health for Community Care, provided an update to 4-Corners Professional Staff on VA's Choice 2.0 plans.

12:30 P.M.; Teleconference

POC: (b)(6)

Summary: Dr. Alaigh, Acting Under Secretary for Health, along with Dr. Yehia, and Kristin Cunningham, Executive Officer to Office of Community Care, VHA, provided a status report of VA's efforts relating to the future of community care. Dr. Alaigh discussed the premise of VA's efforts to reform care in the community, followed by walking staff through VA's core principles for Veterans Choice 2.0 carefully defining each of the principles and linking Choice 2.0 reform efforts to each principle. Dr. Yehia continued the conversation by framing the Secretary's concepts explaining the idea of Choice 2.0 is to have a plan that is both sustainable over the long run while providing Veterans with quality care of their choice. He then defined the features and enablers of the Basic and Preferred plans, which were previously given to Chairman and Ranking Member of SVAC and HVAC. He stressed VA was in the early stages of developing Choice 2.0 (analysis of concept models continues) and that it was critical for VA to not only be open and transparent with all stakeholders, but more importantly, he wanted to hear what Congress thought was within the realm of possibilities (what enablers/features of VA's concepts are tolerable as well as those considered to be NO-GO areas? SVAC minority said billing service connected was problematic; SVAC majority stated co-pays are a major issue with the committee members stating some support while others do not). Staff was also interested in how VSOs felt about the basic and preferred plans, particularly the enablers. Dr. Yehia stated in general terms VSOs were supportive of the features (mainly due to the fact that the basic services provided to Veterans remain intact) of the plans and apprehensive of the enablers. Staff also asked about costs shares, revenue collection (subvention, billing self-referrals who participate in the network, and billing other health insurance plans for services provided), OMB and administration comments with regard to VA efforts, the community care network request for proposal (RFP) and if the RFP was flexible enough to execute VA's concepts, and VA's proposed execution timeline. Dr. Yehia stated the RFP had built in flexibility to support VA efforts for Choice reform and stated the goal was to have legislation in place by

the end of the fiscal year. HVAC majority was pleased with that commenting they wanted something to be done by the summer time. SVAC minority was interested in VA providing additional details, particularly for the models as well as VA providing dollar amounts for each of the features and enablers of all concepts VA is considering. SVAC majority asked if VA was not successful in either obtaining additional enablers (increasing revenues through any and all means) what is the Choice 2.0 alternative? Finally, staff was interested in the next steps of the RFP.

· March 24, 2017. BVA and VBA staff briefed 4-Corners staff on recent developments related to appeals modernization.

3:00 P.M.; Teleconference

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided tomorrow's summary.

Look Ahead- Monday, March 27, 2017

· March 27, 2017. Danny Devine, Deputy Director of Policy and Procedures, Compensation Service, VBA, and Laurine Carson, Assistant Director for Procedures, Compensation Service, VBA, will provide a briefing to SVAC staff regarding VA's efforts to update the disability rating schedule.

1:00 P.M.; Teleconference

POC: (b)(6)

· March 27, 2017. BVA Executive in Charge/Acting Vice Chairman, Dave Spickler and VBA Appeals Management Office Director, David McLenachen, will provide a briefing on Appeals Modernization and the proposed appeals pilot program to SVAC minority staff.

2:00 P.M.; TBD Hart

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

1:30 P.M.; Room: Cannon 334

POC: (b)(6)

· March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.
- H.R. 467 - The VA Scheduling Accountability Act.
- H.R. 907 - The Newborn Care Improvement Act.
- H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
- H.R. 1005 - To improve the provision of adult day health care services for Veterans.
- H.R. 1058 - The VA Provider Equity Act.
- H.R. 1162 - The No Hero Left Untreated Act.
- H.R. 1545- VA Prescription Data Accountability Act of 2017
- Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
- Draft Bill - To prohibit smoking in any VHA facility.

· April 4, 2017. The House Committee on Veterans' Affairs will conduct a hearing on the OIG's Veterans Crisis Line Report.

10:00 A.M.; 334 Cannon

POC: (b)(6)

· April 5, 2017. The HVAC DAMA Subcommittee will hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

10:30 A.M.; Room 334 Cannon HOB

POC: (b)(6)

Agenda

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- HR 1564 (Bergman) Beneficial Travel for VBA (authorization fix)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

McMorris Rogers

Cathy

WA

Meeting

3/24/2017

VA issues and Moving Forward in the 115th

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA Delaware State Veterans Summit

Sen

Klobuchar

Amy

MN

Call

4/4/2017

Burn Pit Legislation

Rep

Brownley

Julia

CA

Meeting

4/4/2017

VA Priorities Rescheduled from 3/15

Rep

Bost

Mike

IL

Meeting

4/4/2017

Appeals Reform Legislation

Rep

O'Rourke

Beto

TX

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Sen

Murray

Patty

WA

Call

4/6/2017

Caregivers

Sen

McCain

John

AZ

Call

3/22/2017

Unknown

Sen

Duckworth

Tammy

IL

Meeting

4/6/2017

TBD

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Wyden

Ron

OR

Meeting

4/6/2017

VCL Backup Contract

Sen

Enzi

Michael

WY

Meeting

4/6/2017

Choice

Sen

Sanders

Bernie

VT

Meeting

3/6/2017

Privatization, Choice Reschedule from 3/23

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)>
Filename: EAS
Last Modified: Fri Mar 24 16:24:29 CDT 2017

Document ID: 0.7.10678.737638-000001

Attachment Name: EAS

Locator: es:\pst*\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5d04792c00: :070052d2a17bf3c3626e46af4511ecbda141ae533b84f54ecc76419e19565675f196

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) </o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Tuesday, March 21, 2017
Date: Mon Mar 20 2017 16:24:34 CDT
Attachments: EAS

All,

Attached is the Morning Report for Tuesday, March 21, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Tuesday, March 21, 2017

Hot Issues

- GAO Final Report on Appeals to be released March 23rd.

Emerging

- None

Congressional Letters and Meeting Requests Received

- None

Monday, March 20, 2017 Events

- March 17, 2017. (Continued - March 9, 2017) Rob Thomas, OI&T, Acting Assistant Secretary, provided a briefing to SVAC minority staff on "VA's Major IT Projects."

2:00 P.M.; 703 VACO

POC: (b)(6)

Summary: Ms. Ricci Mulligan, Executive Director for Budget and Finance, OI&T and Ms. Nicole Mayerhauser, Executive Director for Enterprise Portfolio Management, OI&T provided a general overview on VA's major IT projects and accomplishments to SVAC Minority staff. Information was given on VA's ability to improve the vulnerabilities noted in VAOIG's report. Ms. Mulligan and Ms. Mayerhauser provided further information on VA's IT infrastructure and transformation improvements that focused on improving the Veteran experience.

- March 20, 2017. Dr. Yehia, Deputy Under Secretary for Health for Community Care, briefed SVAC Minority staff along with Sen. Tester's local staff on the Choice Program Scheduling Options for Montana.

10:30 A.M.; Teleconference

POC: (b)(6)

Summary: Dr. Yehia discussed how VA intends to modify the current Choice Program contract to allow VA to work directly with Veterans and community providers in Montana to coordinate medical appointments for those Veterans seeking care through the Veterans Choice Program. This pilot would be similar to those ongoing programs in Alaska and North Dakota. The overall goal would be to improve care coordination for local Montanans. Dr. Yehia then walked staff through how appointments would be scheduled under the contract modification and how that would differ from current practices. Staff was told the modification to the Choice contract would be implemented once the TPA agrees to terms and staff is properly trained to assume the role of scheduling. SVAC staff was also concerned with the TPA's inability to promptly pay claims. Dr. Yehia stated that clean claims are routinely paid in the allotted

time allowed; however, claims would continue to be rejected or denied through no fault of VA or the TPA, but due to VA's inability to pay the claims given the current laws on reimbursements that must be adhered to; highlighting all the more reason for Congress to endorse VA's efforts to move forward with Choice 2.0.

· March 20, 2017. Dr. Baligh Yehia, Assistant Deputy Under Secretary for Health - Community Care briefed the members of Senator Steve Daines's staff regarding the Choice Program.

12:30 P.M., Teleconference

POC: (b)(6)

Summary: Dr. Baligh Yehia, Deputy Under Secretary for Health - Community Care briefed members of Senator Steve Daines staff regarding the Choice Program ahead of his stakeholder listening session in Helena/Ft. Harrison. The call went very well and staff were pleased to get insight ahead of the town hall. Dr. Yehia asked the staff for any outstanding claim balances under Choice so VA can correct these prior to the visit. Dr. Yehia, through Matt Stiner will send Senator Daines staff the Community Care Provider Toolkit and Fact Sheet for local staff in MT to utilize.

· March 20, 2017. Margarita Devlin, Executive Director, Benefits Assistance Service; and Meredith Bedenbaugh-Thomas, Assistant Director, Benefits Assistance Service; briefed staff from Congressman Robert Aderholt's (R-AL-04) office on education and training benefits available to service members upon departing the military.

1:30 P.M.; 235 Cannon House Office Building

POC: (b)(6)

Summary: The Congressman's staff has been meeting with various agencies, including the Department of Defense and the Department of Labor, to discuss opportunities available to separating service members with an interest in careers in agriculture. Ms. Devlin and Ms. Bedenbaugh-Thomas began by discussing the Military Lifecycle plan and how the implementation across all branches would assist military members in their career path from beginning to end of the pipeline. The Congressional staff were particularly interested in apprenticeship and mentorship opportunities related to agriculture and how they are covered by either the GI Bill or Chapter 31 benefits. Ms. Devlin gave an overview of the two programs and how they would be able to be used specifically for an apprenticeship opportunity. Staffers were concerned about the availability of this information for both active duty members of the military and Veterans. Ms. Devlin and Ms. Bedenbaugh-Thomas assured them that there are tools available online to find approved apprenticeships through the Department of Labor, and VA's comparative information about schools. Overall, the Staff was very appreciative for the briefing and would like follow-up information on GI Bill/Vocational Rehab statistics as well as to discuss another briefing specifically on those topics.

Government Accountability Office (GAO) Activity:

Entrance Conference

- March 20, 2017. In response to a request by the Chairs of the House Armed Services Committee and the House Veterans' Affairs Committee, GAO is beginning its work on Reverse Auctions (GAO Code 101428).

GAO's key questions:

- What are the trends in use of reverse auctions over the past 5 years?
- What steps have the agencies taken to improve the use of reverse auctions?
- To what extent did agencies achieve benefits through reverse auctions, such as enhanced competition and savings, with consideration of fees paid?

1:00 P.M.; VACO, Room 632

POC: (b)(6)

Summary: GAO used the meeting to discuss their objective and establish VA points of contacts. In addition to VA, GAO will meet with the Department of Defense, General Service Administration, and Office of Management and Budget. GAO stated they will look at the largest users of reverse auctions in the federal government. Due to VA's limited use of reverse auctions, GAO does not anticipate VA to be a major focus of this review. GAO anticipates conducting site reviews and will narrow down selected sites in the near future.

GAO anticipates the review to last 9-12 months.

Look Ahead- Tuesday, March 21, 2017

- March 21, 2017. Dr. Jennifer Lee, Deputy Under Secretary for Health for Policy and Services and Dr. Joel Scholten, National Director, Physical Medicine and Rehabilitation will brief Representative Sessions, Buck and Jone's offices regarding hyperbaric oxygen therapy.

12:00 P.M.; United States Capitol, Rules Chairman's Office, Room H-314

POC: (b)(6)

- March 21, 2017. Mr. Greg Giddens, Executive Director, Office of Acquisition Logistics & Construction will meet with Congresswoman Ann Kuster (D-NH) and Congressman Beto O'Rourke (D-TX) to discuss VA's ongoing supply chain management reforms.

1:30 P.M.; 1330 Longworth

POC: (b)(6)

· March 21, 2017. Margarita Devlin, Executive Director, Benefits Assistance Service (BAS), will provide a briefing to SVAC staff on the BAS role with the Transition Assistance Program (TAP) and the handover of the TAP Career Technical Training module to DOL-VETS.

2:00 P.M.; 412 Russell

POC: (b)(6)

· March 21, 2017. The HVAC EO Subcommittee has notified VA that they will hold a legislative hearing on a single bill H.R. 1461, entitled the "Veterans, Employees, and Taxpayers Protection Act of 2017," which pertains, in significant part, to the use of official time and probationary employees. VA witnesses are Kimberly Perkins McLeod, Acting Executive Director, Labor Management Relations, accompanied by Rondy Waye, Human Resources Policy Advisor in VA's Office of Human Resources and Management.

2:00 PM.; Room: 334 Cannon HOB

POC: (b)(6)

· March 21, 2017. Secretary Shulkin is taking a call with Sen. Clair McCaskill (D-MO) at the Senator's request. The Senator wishes to discuss her legislation, the Arla Harrell Act (S. 75), and the Veteran who inspired the bill. Among other things, S. 75 shifts the burden of proof to VA to deny benefits claims based on mustard gas exposure; i.e. VA would have to prove a Veteran was not exposed to mustard gas to deny a claim. Mr. Harrell's claim has been repeatedly denied because his service record cannot support his claim for benefits related to mustard gas exposure.

4:45 P.M.; Teleconference

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· March 22, 2017. Joint Hearing of the House and Senate Committee's on Veterans' Affairs to receive the Legislative Presentation of Multiple Veterans Service.

10:00 A.M.; G-50 Dirksen

POC: (b)(6)

· March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans' Affairs, Subcommittee on Health will conduct an oversight hearing on "Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers."

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

· March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

1:30 P.M.; Room: Cannon 334

POC: (b)(6)

· March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.
- H.R. 467 - The VA Scheduling Accountability Act.
- H.R. 907 - The Newborn Care Improvement Act.
- H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
- H.R. 1005 - To improve the provision of adult day health care services for Veterans.
- H.R. 1058 - The VA Provider Equity Act.
- H.R. 1162 - The No Hero Left Untreated Act.
- H.R. 1545- VA Prescription Data Accountability Act of 2017
- Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
- Draft Bill - To prohibit smoking in any VHA facility.

· April 5, 2017. The HVAC Disability and Memorial Affairs Subcommittee will hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

10:30 AM.; Room 334 Cannon HOB

POC: (b)(6)

Agenda

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- HR 1564 (Bergman) Beneficial Travel for VBA (authorization fix)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Brownley

Julia

CA

Meeting

4/4/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

O'Rourke

Beto

TX

Meeting

4/27/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bost

Mike

IL

Meeting

4/27/2017

VA Priorities

To Be Rescheduled from 3/15

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA

State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA

State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA

State Visit Request

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA

Delaware State Veterans Summit

Sen

McCaskill

Claire

MO

Call

3/21/2017

Arla Harrell Act

Sen

Gillibrand

Kirsten

NY

Meeting

3/22/2017

Blue Water Navy

Sen

Sanders

Bernie

VT

Meeting

3/23/2017

Privatization, Choice, Drug Costs

(Meeting in Office of Secretary)

Rep

Mast

Brian

FL

Meeting

4/4/2017

Meet & Greet

Sen

Murray

Patty

WA

Call

3/8/2017

Caregivers

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

Sen

Duckworth

Tammy

IL

Call

3/8/2017

TBD

HVAC Minority Member Retreat

Meeting

(Annapolis)

3/24/2017

SecVA's Way Forward for VA

Rep

McMorris Rogers

Cathy

WA

Meeting

3/24/2017

VA issues and Moving Forward in the 115th

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Sen

Klobuchar

Amy

MN

Call

4/4/2017

Burn Pit Legislation

Rep

Thompson

Mike

CA

Meeting

3/17/2017

Military Veteran Caucus

Sen

Wyden

Ron

OR

Meeting

3/17/2017

VCL Backup Contract

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Mon Mar 20 16:24:34 CDT 2017

Document ID: 0.7.10678.735735-000001

Attachment Name: EAS

Locator: es:\pst*\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5d84992c00: :0700fc70dad3ef2dca21dd993be3c4212f0c9ba848ad265151df44ac6e960d4a582b

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) </o=va/ou=vba
philadelphia/cn=recipients/cn(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Wednesday, March 22, 2017
Date: Tue Mar 21 2017 16:56:10 CDT
Attachments: EAS

All,

Attached is the Morning Report for Wednesday, March 22, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Wednesday, March 22, 2017

Hot Issues

- GAO Final Report on Appeals to be released March 23rd.

Emerging

- None

Congressional Letters and Meeting Requests Received

- March 20, 2017. Chairman P. Roe (HVAC), and Rep. Jackie Walorski (R-IN) expressed concern over an investigation by the Drug Enforcement Administration at a VA medical facility in Indiana.
 - o Received March 21, 2017: VAIQ #7782287

Tuesday, March 21, 2017 Events

- March 21, 2017. Dr. Jennifer Lee, Deputy Under Secretary for Health for Policy and Services and Dr. Joel Scholten, National Director, Physical Medicine and Rehabilitation briefed Representative Sessions, Buck and Jone's offices regarding hyperbaric oxygen therapy.

12:00 P.M.; United States Capitol, Rules Chairman's Office, Room H-314

POC: (b)(6)

Summary: Rep. Sessions made a formal request and stated he would put in writing to VA that he will find the funds for a hyperbaric chamber study. He promised his team by Monday he would provide VA with all their analysis, data, and research for such a study next week. Dr. Lee stated she and her team would meet with Rep. Sessions next week to follow up on today's discussion.

- March 21, 2017. VBA Director Education Service Rob Worley, Assistant Director for Policy and Procedures James Ruhlman, and Deputy Director of Operations Charmain Bogue briefed HVAC EO majority and SVAC majority and minority staff on GI Bill processing payments.

12:00 P.M.; Teleconference

POC: (b)(6)

Summary: VBA staff provided a detailed briefing on recently identified problems with GI Bill payment

processing to HVAC EO majority and SVAC majority and minority staff. VBA staff provided background information and the current status of a payment issue that is causing delays for GI Bill recipients. HVAC and SVAC staff expressed considerable concern regarding payment delays and also discussed the potential for equitable relief cases. VBA staff discussed how this issue was identified during an internal audit and that steps are being actively taken to prioritize claims, work with DoD to provide corrections, and strengthen internal training to prevent similar payment disruptions.

· March 21, 2017. Mr. Greg Giddens, Executive Director, Office of Acquisition Logistics & Construction met with Congresswoman Ann Kuster (D-NH) and Congressman Beto O'Rourke (D-TX) to discuss VA's ongoing supply chain management reforms.

1:30 P.M.; 1330 Longworth

POC: (b)(6)

Summary: Mr. Giddens provided an update on five areas in which the department is focusing efforts to transform the supply chain, including healthcare commodity staffing, MSPV-NG Formulary contracts, and deployment of a Graphical User Interface (GUI) Overlay. He highlighted significant progress with meeting targeted staffing levels and the deployment of the GUI overlay. Congresswoman Kuster was extremely pleased with the update and asked how Congress could help. Staff members in attendance focused questions on key milestones and dates for delivery. They also continued to express interest in the department's partnership with USDA to deploy an integrated financial management system enterprise-wide.

· March 21, 2017. Margarita Devlin, Executive Director, Benefits Assistance Service (BAS), briefed SVAC staff on the BAS role with the Transition Assistance Program (TAP) and the handover of the TAP Career Technical Training module to DOL-VETS.

2:00 P.M.; 412 Russell

POC: (b)(6)

Summary: Benefits Assistance Service (BAS) Executive Director Devlin and BAS Assistant Director Bedenbaugh-Thomas had a lively sharing of ideas with SVAC majority and minority staff regarding the role of the BAS, transition program touchpoints and the handover of the TAP Career Technical Training module to the Department of Labor. SVAC seemed appreciative of the briefing and expressed interest in TAP outcome metrics and BAS's exploration of different measures of transition outcomes.

· March 21, 2017. The HVAC EO Subcommittee held a legislative hearing on a single bill H.R. 1461, entitled the "Veterans, Employees, and Taxpayers Protection Act of 2017," which pertains, in significant part, to the use of official time and probationary employees. VA witnesses are Kimberly Perkins McLeod, Acting Executive Director, Labor Management Relations, accompanied by Rondy Waye, Human Resources Policy Advisor in VA's Office of Human Resources and Management.

2:00 P.M.; Room: 334 Cannon HOB

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided tomorrow's summary.

Government Accountability Office (GAO) Activity:

Exit Conference

· March 21, 2017. GAO is ready to present its findings on Incremental Development FITARA (GAO Code 101036). GAO conducted this review in response to a request by the Chairman and Ranking Members of the House Committee on Oversight and Government Reform and its Subcommittees on Information Technology and Government Operations.

GAO's objectives:

- Analyze agencies' reported use of incremental development and the factors affecting delivery rates; and
- Evaluate agencies' policies and procedures for CIO certification of incremental development in accordance with FITARA.

3:30 P.M.; VACO, Room 511

POC: (b)(6)

Summary: GAO provided a statement of facts prior to the meeting that VA overall agreed with. GAO found that VA's Chief Information Officer incremental development policy does not adequately detail VA's incremental certification process.

GAO anticipates providing their report for comment in May 2017, allowing 30 days to comment. GAO anticipates making a recommendation to VA to address any deficiencies and noncompliance with legislative reporting requirements.

GAO stated they anticipate issuing their report in July 2017.

Look Ahead- Wednesday, March 22, 2017

· March 22, 2017. Dr. Karen Drexler, National Mental Health Director-Addictive Disorders and Dr. Heather Chapman, Director of the Cleveland VA Gambling Treatment Program will provide a briefing on treatments for Gambling Disorders to the staff of Sen. Warren (MA).

9:00 A.M.; Teleconference

POC: (b)(6)

· March 22, 2017. Joint Hearing of the House and Senate Committee's on Veterans' Affairs to receive the Legislative Presentation of Multiple Veterans Service.

10:00 A.M.; G-50 Dirksen

POC: (b)(6)

· March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans' Affairs, Subcommittee on Health will conduct an oversight hearing on "Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers."

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

· March 22, 2017. Cheryl Mason, Interim Principal Deputy Vice Chairman, BVA, and Dave McLenachen, Director, Appeals Management Office, will meet with HVAC DAMA Subcommittee Chairman, Bost in advance of the Subcommittee's Roundtable on Appeals.

2:00 P.M.; 1440 Longworth

POC: (b)(6)

· March 22, 2017. Mr. Steven Young, Deputy Under Secretary for Operations Management, will brief Sen. Wyden's staff on the Veterans Crisis Line back-up call center contracts.

4:00 P.M.; 221 Dirksen

POC: (b)(6)

· March 22, 2017. Secretary Shulkin will meet with Sen. Gillibrand (NY) to discuss her newest bill S. 422 Blue Water Navy Vietnam Veterans Act of 2017.

4:15 P.M.; 478 Russell

POC: (b)(6)

· March 22, 2017. Dr. Yehia, Deputy Under Secretary for Health for Community Care, will provide

an information brief on a TN VA community care cardiology proposal to HVAC Majority staff.

5:00 P.M.; Teleconference

POC: (b)(6)

Government Accountability Office (GAO) Activity:

Exit Conferences

· March 22, 2017. GAO is ready to present its findings on Graduate Medical Education (GME) Structure and Funding (GAO Code 100504). GAO conducted this review in response to a request by the Chairman of the U.S. House of Representatives Committee on Ways and Means, the Chair of the Republican Conference, and 25 other Members of Congress.

GAO Objective:

*GAO was asked to review programs that provide federal funding for GME, including programs funded through the Veterans Health Administration, and report on topics including GME funding, oversight, and the geographic distribution of medical residents.

12:00 P.M.; VACO, Room 532

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VAVSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

1:30 P.M.; Room: Cannon 334

POC: (b)(6)

· March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by

Susan Blauert, Deputy Chief Counsel.

8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
 - H.R. 95 - The Veterans' Access to Child Care Act.
 - H.R. 467 - The VA Scheduling Accountability Act.
 - H.R. 907 - The Newborn Care Improvement Act.
 - H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
 - H.R. 1005 - To improve the provision of adult day health care services for Veterans.
 - H.R. 1058 - The VA Provider Equity Act.
 - H.R. 1162 - The No Hero Left Untreated Act.
 - H.R. 1545- VA Prescription Data Accountability Act of 2017
 - Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
 - Draft Bill - To prohibit smoking in any VHA facility.
-
- April 4, 2017. The House Committee on Veterans' Affairs will conduct a hearing on the OIG's Veterans Crisis Line Report.

10:00 A.M.; 334 Cannon

POC: (b)(6)

- April 5, 2017. The HVAC Disability and Memorial Affairs Subcommittee will hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

10:30 A.M.; Room 334 Cannon HOB

POC: (b)(6)

Agenda

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA

- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- HR 1564 (Bergman) Beneficial Travel for VBA (authorization fix)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Brownley

Julia

CA

Meeting

4/4/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

O'Rourke

Beto

TX

Meeting

4/27/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bost

Mike

IL

Meeting

4/27/2017

VA Priorities

To Be Rescheduled from 3/15

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA

State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA

State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA

State Visit Request

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA

Delaware State Veterans Summit

Sen

McCaskill

Claire

MO

Call

3/21/2017

Arla Harrell Act

Sen

Gillibrand

Kirsten

NY

Meeting

3/22/2017

Blue Water Navy

Sen

Sanders

Bernie

VT

Meeting

3/23/2017

Privatization, Choice, Drug Costs

(Meeting in Office of Secretary)

Rep

Mast

Brian

FL

Meeting

4/4/2017

Meet & Greet

Sen

Murray

Patty

WA

Call

3/8/2017

Caregivers

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

Sen

Duckworth

Tammy

IL

Call

3/8/2017

TBD

HVAC Minority Member Retreat

Meeting

(Annapolis)

3/24/2017

SecVA's Way Forward for VA

Rep

McMorris Rogers

Cathy

WA

Meeting

3/24/2017

VA issues and Moving Forward in the 115th

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Sen

Klobuchar

Amy

MN

Call

4/4/2017

Burn Pit Legislation

Rep

Thompson

Mike

CA

Meeting

3/17/2017

Military Veteran Caucus

Sen

Wyden

Ron

OR

Meeting

3/17/2017

VCL Backup Contract

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Tue Mar 21 16:56:10 CDT 2017

Document ID: 0.7.10678.736115-000001

Attachment Name: EAS

Locator: esapst/*:\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\VACODJS1.pst:00000000ddd1d847dc44de4ebb65729b0dd7de5d248e2c00: :0700430f9b19e42220b92bd31e4bf0933b3dd05e9f55248db1eb12b2730940ec94e4

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) /o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b)(6)
To:
Cc:
Bcc:
Subject: Morning Report 4/24/2017
Date: Fri Apr 21 2017 16:01:30 CDT
Attachments: image001
image002.png
Stand up -April 24.docx

All,

Attached is the Morning Report for Monday, April 24, 2017. This document is for internal use only.

(b)(6)

Program Analyst, Corporate Enterprise
Office of Congressional and Legislative Affairs
Department of Veterans Affairs
810 Vermont Ave., NW
Des (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Monday, April 24, 2017

Hot Issues

***** April 28, 2017. HVAC Ranking Member Walz and committee members Representatives Kuster, Takano, Brownley, and O'Rourke, along with Representatives Connolly (VA) and Holmes Norton (DC) will visit DC VA Medical Center for a walking tour and an update on VA's response to the IG Report on Health Care Inspection at the Medical Center.

8:00-10:00 A.M.; DC VAMC

POC: (b)(6)

Emerging

***** None

Congressional Letters and Meeting Requests Received

***** April 20, 2017. Sen Tammy Baldwin (D-WI) expressed support for BraveHearts' grant application.

- o Received April 21, 2017; VAIQ 7791103.

***** April 20, 2017. Sens Patty Murray (D-WA), Maria Cantwell (D-WA) and Reps (Denny Heck (D-WA), and Derek Kilmer (D-WA) expressed support for Metro Parks Tacoma's grant application.

- o Received April 21, 2017; VAIQ 7791101.

Friday, April 21, 2017 Events

***** April 20, 2017. SVAC staff members Jillian Workman and Eric Gardiner traveled to VA's National Center on Homelessness Among Veterans and the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, PA to conduct routine oversight.

POC: (b)(6)

Summary: The staff first received a brief from the National Center on Homelessness (NCHV) on the organization's mission, history, structure, policy impacts and future directions. The staff was particularly interested in the NCHV's pilot programs and any expansion efforts that could include Montana and Georgia. NCHV also explained they were moving towards exploring certificate program possibilities, applying research findings in the field and assuring collaboration between federal and non-federal homeless providers.

After the brief by NCHV, the staff received an overview and discussed care in the community with the facility's leadership. The facility's leader explained that of the 74,801 pending appointments for PVAMC and surrounding CBOCs, 95.5% of all appointments are scheduled within 30 days of the patient's desired date. The facility at the staff's request discussed barriers in the Choice program including the types of complaints they sent to HealthNet. The Committee requested a breakdown of the complaints issued to HealthNet. The staff also toured the Scheduling Call Center, Emergency Department, Behavioral Health Department and Women's Clinic. The staff was impressed by the tour and expressed interest in having Senator Tester attend the Women Veteran's Health Center Dedication on May 5th, 2017.

*April 21, 2017. Craig Robinson, ADAS for National Healthcare Acquisitions; Steve Thomas, Director, National Contracting Service, 90N-P, Office of Acquisition & Logistics and John DuFon, Chief Logistics Officer, VHA briefed HVAC O&I Contracts Investigator, Bill Mallison, on the procurement of High Tech Medical Equipment.

11:00 A.M.; Teleconference

POC: (b)(6)

Summary: HVAC staff reiterated its concern regarding the process by which the NAC purchases high tech medical equipment for VHA facilities in the wake of last year's SCOTUS decision on Kingdomware. The staff inquired about the delays with the Consolidation RFQ originally scheduled for 2016 and asked to review the business case for award. VA staff provided an update on the schedule and explained the business case is still in development.

GAO Activities

Entrance Conference

***** April 21, 2017. GAO presented its findings on Federal Government Efforts to Reduce the Use of Social Security Numbers (GAO job code 100830). GAO conducted this review in response to a request made by the Chair of the House Committee on Oversight and Government Reform and the Chair of the Subcommittee on Social Security from the House Committee on Ways and Means.

GAO's objectives were to examine:

***** To what extent have agencies developed and executed plans to eliminate the use and display of SSNs?

***** What government-wide initiatives have been undertaken to assist agencies in eliminating their unnecessary use of SSNs and what have been their results?

***** What remaining challenges have agencies identified to reducing the continued use of SSNs as personal identifiers?

Summary: GAO provided a statement of facts prior to the meeting that was discussed at a high level. GAO anticipates providing its draft report late May 2017 and allowing 30 days to comment. GAO stated they do not anticipate making any recommendations to VA.

GAO anticipates issuing their final report by August 2017.

Look Ahead- Monday, April 24, 2017

***** April 24, 2017. Ron Burke, Assistant Under Secretary for Field Operations VBACO, Eric Mandle, Consultant, Compensation Service, VBA and Brad Flohr, Senior Advisor for Compensation Service, VBA will speak with Mr. Chad Sydnor and staff members from Sen. Burr's(NC) office regarding status update on Camp Lejeune process of claims and benefits.

2:00 P.M.

POC: (b)(6)

***** April 24, 2017. Representatives of the Board of Veterans Appeals and the Veterans Benefits Administration, as well as staff from the Office of Management, meet with Senate Veterans Affairs Committee and Senate MilCon/VA Appropriations Committee staff regarding appeals modernization legislation.

4:00 P.M.; 418 Russell

POC: (b)(6)

***** April 24, 2017. Representatives of the Board of Veterans Appeals and the Veterans Benefits Administration will meet with Senate Veterans Affairs Committee and House Veterans' Disability Assistance and Memorial Affairs Majority staff regarding appeals modernization legislation, including a planned May 2 House Veterans' Affairs Committee hearing on that topic.

5:15 P.M.; 338 Cannon

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

*POSTPONED TBD. The HVAC EO Subcommittee intends to hold a legislative hearing on the agenda set out below. Curtis Coy, Deputy Under Secretary for Economic Opportunity will be representing the VA.

Agenda

*H.R. 43 - To authorize the use of Post-9/11 Educational Assistance to pursue independent study programs.
*H.R. 245 - Veterans' Education Equity Act.
*H.R. 1104 - Veterans To Enhance Studies Through Accessibility Act.
*H.R. 1112 - Shauna Hill Post 9/11 Education Benefits Transferability Act.
*H.R. 1216 - Protecting Veterans From School Closures Act of 2017
*H.R. 1331 - Veterans Success on Campus Act of 2017.
*H.R. 1384 - Reserve Component Benefits Parity Act
*H.R. 1793 - Veteran Education Priority Enrollment Act of 2017
*H.R. 1956 - To increase the amounts of educational assistance payable under Survivors' and Dependents' Educational Assistance Program of the Department of Veterans Affairs.
*H.R. 1989 - Veteran Employment Through Technology Education Courses Act.
*H.R. 1994 - Vocational Education and Training Enhancement for Reintegration Assistance Now Act
*H.R. 2099 - GI Bill Fairness Act of 2017.
*H.R. 2100 - Work-Study for Student Veterans Act.
*H.R. 2103 - To include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program.
*H.R. 2108 - GI Bill STEM Extension Act of 2017.
*Draft Bill - GI Bill Processing Improvement Act.
*Draft Bill - To consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of the Department of Veterans Affairs.
*Draft Bill - To provide for an election requirement and reduction in basic pay for members of the Armed Forces entitled to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program.

POC: (b)(6)

***** April 26, 2017. The Senate Homeland Security and Governmental Affairs Committee intends to hold a hearing on construction of VA medical facilities.

10:00 A.M., 342 Dirksen.

POC: (b)(6)

***** April 27, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's suicide prevention efforts.

Time 10:30 A.M.; Location Dirksen 124

POC: Office of Management, (b)(6)

Testimony Status: in development

***** May 2, 2017. The House Veterans' Affairs Committee will hold a legislative hearing on a draft bill entitled the "Veterans Appeals Improvement and Modernization Act." VA witnesses have not been finalized.

10:00 a.m., Cannon 334

POC: (b)(6)

***** May 3, 2017. The House Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's FY2018 budget.

Time 10:00 A.M.; Location Rayburn 2359

POC: Office of Management (b)(6)

Testimony Status: in development

+

***** May 4, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on telehealth/telemedicine.

Time TBD.; Location TBD

POC: Office of Management

Testimony Status: in development

***** May 10, 2017. SVAC will have an oversight hearing on VA's Choice Program and the Future of Choice and care in the community. The committee has asked Secretary Shulkin to be VA's lead witness.

2:30 P.M., 418 Russell Senate Office Building

POC: (b)(6)

***** May 11, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on the Veterans Choice Program and the future of non-VA care after that program ends.

Time 10:30am Location Dirksen 124

POC: Office of Management (b)(6)

Testimony Status: in development

***** May 17, 2017. SVAC intends to hold a legislative hearing on the draft agenda set out below. Lead Witness Jennifer S. Lee, M.D., Deputy Under Secretary for Health For Policy and Services, Veterans Health Administration. Accompanied by: Margaret Kabat, National Director, Caregiver Support Program, Veterans Health Administration; Jan Frye, Deputy Assistant Secretary, Office of Acquisition and Logistics, Office of Acquisition, Logistics, and Construction; and James Ruhlman, Assistant Director for Policy & Procedures, Veterans Benefit Administration.

2:30 P.M.; 412 Russell SOB

POC: (b)(6)

Tentative Agenda

- ***** S. 23, Biological Implant Tracking and Veteran Safety Act of 2017 (Cassidy, Tester)
- ***** S. 112, Creating a Reliable Environment for Veterans' Dependents Act (Heller, Murray)
- ***** S. 324, State Veterans Home Adult Day Health Care Improvement Act (Hatch/Hirono, Boozman, Heller, Tillis)
- ***** S. 543, Performance Accountability and Contractor Transparency Act of 2017 (Tester, Murray, Manchin)
- ***** S. 591, Military and Veteran Caregivers Services Improvement Act of 2017 (Murray, Tester, Sanders, Brown, Blumenthal, Hirono, Manchin)
- ***** S. 609, Chiropractic Care Available to All Veterans Act of 2017 (Moran, Tester, Blumenthal, Brown)
- ***** S. 681, Deborah Sampson Act (Tester/Boozman, Murray, Blumenthal, Brown)
- ***** S. 764, Veterans Education Priority Enrollment Act of 2017 (Brown, Tillis)
- ***** S. 784, Veterans' Compensation Cost-of-Living Adjustment Act of 2017 (Isakson/Tester)
- ***** S. 804, Women Veterans Access to Quality Care Act (Heller)
- ***** S. 899, Serving our Rural Veterans Act (Sullivan, Tester)
- ***** S. ___, Veteran Partners' Efforts to Enhance Reintegration Act (Blumenthal)
- S. ___, Department of Veterans Affairs Veteran Transition Improvement Act (Hirono)

***** May 24, 2017. (tentative). HVAC intends to hold a hearing on VA's FY2018 budget request.

Time and Location TBD

POC: Office of Management

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

Rep

Arrington

Jodey

TX

Meeting

4/27/2017

VA Priorities – Proactive

HVAC Minority Member Retreat

Meeting

5/1/2017

VA Priorities - Armed Forces Retirement Home (Washington, DC)

Chair Miller Portrait Unveiling

Reception

5/3/2017

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Sen

Sanders

Bernie

VT

Meeting

5/4/2017

Privatization, Choice Reschedule from 3/23 and 4/6

Sen/Rep

Thune

Rounds

Noem

SD

Meeting

5/4/2017

Black Hills

GI Film Festival

Reception

5/24/2017

Rep

Brownley

Julia

CA

Meeting

3/28/2017

VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Kihuen

Ruben

NV

Meeting

4/4/2017

Closure of Ely, NV Clinic

Owner: (b)(6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: image001 <extracted>
Last Modified: Fri Apr 21 16:01:30 CDT 2017

This document contains proprietary information and should not be released, in whole or in part, to non -VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or **competing** Member offices that should not be shared with other congressional entities

Owner: (b)(6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: image002.png
Last Modified: Fri Apr 21 16:01:30 CDT 2017

This document contains information that should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or competing Member offices that should not be shared with other entities.

Owner: (b)(6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: Stand up -April 24.docx
Last Modified: Fri Apr 21 16:01:30 CDT 2017

FOR INTERNAL USE ONLY

Secretary's Morning Report
Prepared by the Office of Congressional & Legislative Affairs
Monday, April 24, 2017

This document contains proprietary information and should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or **competing** Member offices that should not be shared with other congressional entities

Hot Issues

April 28, 2017. HVAC Ranking Member Walz and committee members Representatives Kuster, Takano, Brownley, and O'Rourke, along with Representatives Connolly (VA) and Holmes Norton (DC) will visit DC VA Medical Center for a walking tour and an update on VA's response to the IG Report on Health Care Inspection at the Medical Center.
 8:00-10:00 A.M.; DC VAMC
 POC: David Brant, 1-6463

Emerging

None

Congressional Letters and Meeting Requests Received

April 20, 2017. Sen Tammy Baldwin (D-WI) expressed support for BraveHearts' grant application.

- Received April 21, 2017; VAIQ 7791103.

April 20, 2017. Sens Patty Murray (D-WA), Maria Cantwell (D-WA) and Reps (Denny Heck (D-WA), and Derek Kilmer (D-WA) expressed support for Metro Parks Tacoma's grant application.

- Received April 21, 2017; VAIQ 7791101.

Friday, April 21, 2017 Events

April 20, 2017. SVAC staff members Jillian Workman and Eric Gardiner traveled to VA's National Center on Homelessness Among Veterans and the Corporal Michael J. Crescenzo VA Medical Center in Philadelphia, PA to conduct routine oversight.

POC: Brendon Gehrke, 1-7318

Summary: The staff first received a brief from the National Center on Homelessness (NCHV) on the organization's mission, history, structure, policy impacts and future directions. The staff was particularly interested in the NCHV's pilot programs and any expansion efforts that could include Montana and Georgia. NCHV also explained they were moving towards exploring certificate program possibilities, applying research findings in the field and assuring collaboration between federal and non-federal homeless providers.

After the brief by NCHV, the staff received an overview and discussed care in the community with the facility's leadership. The facility's leader explained that of the 74,801

FOR INTERNAL USE ONLY

pending appointments for PVAMC and surrounding CBOCs, 95.5% of all appointments are scheduled within 30 days of the patient's desired date. The facility at the staff's request discussed barriers in the Choice program including the types of complaints they sent to HealthNet. The Committee requested a breakdown of the complaints issued to HealthNet. The staff also toured the Scheduling Call Center, Emergency Department, Behavioral Health Department and Women's Clinic. The staff was impressed by the tour and expressed interest in having Senator Tester attend the Women Veteran's Health Center Dedication on May 5th, 2017.

April 21, 2017. Craig Robinson, ADAS for National Healthcare Acquisitions; Steve Thomas, Director, National Contracting Service, 90N-P, Office of Acquisition & Logistics and John DuFon, Chief Logistics Officer, VHA briefed HVAC O&I Contracts Investigator, Bill Mallison, on the procurement of High Tech Medical Equipment.

11:00 A.M.; Teleconference

POC: Omar Boulware, 1-6468

Summary: HVAC staff reiterated its concern regarding the process by which the NAC purchases high tech medical equipment for VHA facilities in the wake of last year's SCOTUS decision on Kingdomware. The staff inquired about the delays with the Consolidation RFQ originally scheduled for 2016 and asked to review the business case for award. VA staff provided an update on the schedule and explained the business case is still in development.

GAO Activities **Entrance Conference**

April 21, 2017. GAO presented its findings on ***Federal Government Efforts to Reduce the Use of Social Security Numbers*** (GAO job code 100830). GAO conducted this review in response to a request made by the Chair of the House Committee on Oversight and Government Reform and the Chair of the Subcommittee on Social Security from the House Committee on Ways and Means.

GAO's objectives were to examine:

To what extent have agencies developed and executed plans to eliminate the use and display of SSNs?

What government-wide initiatives have been undertaken to assist agencies in eliminating their unnecessary use of SSNs and what have been their results?

What remaining challenges have agencies identified to reducing the continued use of SSNs as personal identifiers?

Summary: GAO provided a statement of facts prior to the meeting that was discussed at a high level. GAO anticipates providing its draft report late May 2017 and allowing 30 days to comment. GAO stated they do not anticipate making any recommendations to VA.

GAO anticipates issuing their final report by August 2017.

FOR INTERNAL USE ONLY

Look Ahead- Monday, April 24, 2017

April 24, 2017. Ron Burke, Assistant Under Secretary for Field Operations VBACO, Eric Mandle, Consultant, Compensation Service, VBA and Brad Flohr, Senior Advisor for Compensation Service, VBA will speak with Mr. Chad Sydnor and staff members from Sen. Burr's(NC) office regarding status update on Camp Lejeune process of claims and benefits.
2:00 P.M.

POC: (b)(6)

April 24, 2017. Representatives of the Board of Veterans Appeals and the Veterans Benefits Administration, as well as staff from the Office of Management, meet with Senate Veterans Affairs Committee and Senate MilCon/VA Appropriations Committee staff regarding appeals modernization legislation.

4:00 P.M.; 418 Russell

POC: (b)(6)

April 24, 2017. Representatives of the Board of Veterans Appeals and the Veterans Benefits Administration will meet with Senate Veterans Affairs Committee and House Veterans' Disability Assistance and Memorial Affairs Majority staff regarding appeals modernization legislation, including a planned May 2 House Veterans' Affairs Committee hearing on that topic.

5:15 P.M.; 338 Cannon

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

POSTPONED TBD. The HVAC EO Subcommittee intends to hold a legislative hearing on the agenda set out below. Curtis Coy, Deputy Under Secretary for Economic Opportunity will be representing the VA.

Agenda

- **H.R. 43** - To authorize the use of Post-9/11 Educational Assistance to pursue independent study programs.
- **H.R. 245** - Veterans' Education Equity Act.
- **H.R. 1104** - Veterans To Enhance Studies Through Accessibility Act.
- **H.R. 1112** - Shauna Hill Post p/11 Education Benefits Transferability Act.
- **H.R. 1216** - Protecting Veterans From School Closures Act of 2017
- **H.R. 1331** - Veterans Success on Campus Act of 2017.
- **H.R. 1384** – Reserve Component Benefits Parity Act
- **H.R. 1793** – Veteran Education Priority Enrollment Act of 2017
- **H.R. 1956** - To increase the amounts of educational assistance payable under Survivors' and Dependents' Educational Assistance Program of the Department of Veterans Affairs.
- **H.R. 1989** - Veteran Employment Through Technology Education Courses Act.
- **H.R. 1994** – Vocational Education and Training Enhancement for Reintegration Assistance Now Act
- **H.R. 2099** - GI Bill Fairness Act of 2017.

FOR INTERNAL USE ONLY

- **H.R. 2100** - Work-Study for Student Veterans Act.
- **H.R. 2103** - To include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program.
- **H.R. 2108** - GI Bill STEM Extension Act of 2017.
- **Draft Bill** - GI Bill Processing Improvement Act.
- **Draft Bill** - To consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of the Department of Veterans Affairs.
- **Draft Bill** - To provide for an election requirement and reduction in basic pay for members of the Armed Forces entitled to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program.

POC: (b)(6)

April 26, 2017. The Senate Homeland Security and Governmental Affairs Committee intends to hold a hearing on construction of VA medical facilities.

10:00 A.M., 342 Dirksen.

POC: (b)(6)

April 27, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's suicide prevention efforts.

Time 10:30 A.M.; Location Dirksen 124

POC: Office of Management, Kristy Shea, 1-6437

Testimony Status: in development

May 2, 2017. The House Veterans' Affairs Committee will hold a legislative hearing on a draft bill entitled the "Veterans Appeals Improvement and Modernization Act." VA witnesses have not been finalized.

10:00 a.m., Cannon 334

POC: (b)(6)

May 3, 2017. The House Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's FY2018 budget.

Time 10:00 A.M.; Location Rayburn 2359

POC: Office of Management, (b)(6)

Testimony Status: in development

+

May 4, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on telehealth/telemedicine.

Time TBD.; Location TBD

POC: Office of Management

Testimony Status: in development

May 10, 2017. SVAC will have an oversight hearing on VA's Choice Program and the Future of Choice and care in the community. The committee has asked Secretary Shulkin to be VA's lead witness.

2:30 P.M., 418 Russell Senate Office Building

POC: (b)(6)

FOR INTERNAL USE ONLY

May 11, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on the Veterans Choice Program and the future of non-VA care after that program ends.

Time 10:30am Location Dirksen 124

POC: Office of Management, (b)(6)

Testimony Status: in development

May 17, 2017. SVAC intends to hold a legislative hearing on the draft agenda set out below.

Lead Witness Jennifer S. Lee, M.D., Deputy Under Secretary for Health For Policy and Services, Veterans Health Administration. Accompanied by: Margaret Kabat, National Director, Caregiver Support Program, Veterans Health Administration; Jan Frye, Deputy Assistant Secretary, Office of Acquisition and Logistics, Office of Acquisition, Logistics, and Construction; and James Ruhlman, Assistant Director for Policy & Procedures, Veterans Benefit Administration.

2:30 P.M.; 412 Russell SOB

POC: (b)(6)

Tentative Agenda

S. 23, Biological Implant Tracking and Veteran Safety Act of 2017 (Cassidy, Tester)

S. 112, Creating a Reliable Environment for Veterans' Dependents Act (Heller, Murray)

S. 324, State Veterans Home Adult Day Health Care Improvement Act (Hatch/Hirono, Boozman, Heller, Tillis)

S. 543, Performance Accountability and Contractor Transparency Act of 2017 (Tester, Murray, Manchin)

S. 591, Military and Veteran Caregivers Services Improvement Act of 2017 (Murray, Tester, Sanders, Brown, Blumenthal, Hirono, Manchin)

S. 609, Chiropractic Care Available to All Veterans Act of 2017 (Moran, Tester, Blumenthal, Brown)

S. 681, Deborah Sampson Act (Tester/Boozman, Murray, Blumenthal, Brown)

S. 764, Veterans Education Priority Enrollment Act of 2017 (Brown, Tillis)

S. 784, Veterans' Compensation Cost-of-Living Adjustment Act of 2017 (Isakson/Tester)

S. 804, Women Veterans Access to Quality Care Act (Heller)

S. 899, Serving our Rural Veterans Act (Sullivan, Tester)

S. ____, Veteran Partners' Efforts to Enhance Reintegration Act (Blumenthal)

S. ____, Department of Veterans Affairs Veteran Transition Improvement Act (Hirono)

May 24, 2017. (tentative). HVAC intends to hold a hearing on VA's FY2018 budget request.

Time and Location TBD

POC: Office of Management

Member Engagement Requests for Senior Leaders

Sen/Rep	Last Name	First Name	State	Type of Engagement	Received	Date Scheduled	Topic
Rep	Bergman	Jack	MI	Meeting		4/27/2017	VA Priorities Rescheduled from 3/15

FOR INTERNAL USE ONLY

Rep	Mast	Brian	FL	Meeting		4/27/2017	Meet & Greet
Rep	Sablan	Gregorio	NMI	Meeting		4/27/2017	Access to Care in the Northern Marianas Islands
Rep	Arrington	Jodey	TX	Meeting		4/27/2017	VA Priorities – Proactive
	HVAC Minority Member Retreat			Meeting		5/1/2017	VA Priorities - Armed Forces Retirement Home (Washington, DC)
	Chair Miller Portrait Unveiling			Reception		5/3/2017	
Rep	Thompson	Mike	CA	Meeting		5/3/2017	Military Veteran Caucus
Rep	Kuster	Ann McClane	NH	Meeting		5/3/2017	Womens Caucus
Sen	Sanders	Bernie	VT	Meeting		5/4/2017	Privatization, Choice Reschedule from 3/23 and 4/6
Sen/Rep	Thune Rounds Noem		SD	Meeting		5/4/2017	Black Hills
	GI Film Festival			Reception		5/24/2017	
Rep	Brownley	Julia	CA	Meeting	3/28/2017		VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict
Sen	Sullivan	Dan	AK	Travel	2/1/2017		SecVA State Visit Request
Sen	Tester	Jon	MT	Travel	2/1/2017		SecVA State Visit Request
Sen	Manchin	Joe	WV	Travel	2/1/2017		SecVA State Visit Request
Sen	Daines	Steve	MT	Travel	1/25/2017		Ft Harrison
Rep	Esty	Elizabeth	CT	Travel	3/15/2017		Newington & Farmington, CT
Rep	Kuster	Ann McClane	NH	Travel	3/15/2017		Nashua, NH Homelessness/Suicide
Rep	Bacon	Don	NE	Meeting	3/23/2017		Omaha Ambulatory Care Center
Rep	Kihuen	Ruben	NV	Meeting	4/4/2017		Closure of Ely, NV Clinic

From: (b)(6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report 4/19/2017
Date: Tue Apr 18 2017 16:23:12 CDT
Attachments: image001
image002.png
Stand up -April 19.docx

All,

Attached is the Morning Report for Wednesday, April 19, 2017. This document is for internal use only.

(b)(6)

Program Analyst, Corporate Enterprise
Office of Congressional and Legislative Affairs
Department of Veterans Affairs
810 Vermont Ave., NW
Desk: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Wednesday, April 19, 2017

Hot Issues

***** None

Emerging

***** None

Congressional Letters and Meeting Requests Received

*April 17, 2017. Chairman Jack Bergman (HVAC O&I) requested Excel spreadsheets regarding logistics service purchase at the DC VAMC.

*Received April 18, 2017; VAIQ 7789852.

*April 17, 2017. Reps. Sam Graves (R-GA) and Emanuel Cleaver (D-MO) inquired in VA's plan for increasing women's health services at VA facilities.

*Received April 18, 2017; VAIQ 7789848

Tuesday, April 18, 2017 Events

***** April 17, 2017. Mr. Lawrence Connell, Director at the Department of Veterans Affairs (VA) Medical Center in Washington, D.C. and Mr. Joseph Williams, Network Director VISN 5, conducted a conference call update with staffers from the 4 Corners and Member Offices from DC, Maryland and Virginia.

4:00 P.M.; Teleconference

POC: (b)(6)

Summary: Majority and Minority staffers from HVAC and SVAC as well as personal staff from interested Member offices in the DC VA Medical Center's catchment area and elsewhere were on line. This was a follow up to the call Secretary Shulkin hosted on Thursday, April 13, after release of the Office of Inspector General (OIG) Health Care Inspection Interim Report. Mr. Connell, provided an overview describing the events that led to the OIG investigation. The facility Director detailed specific actions

taken at the facility, VISN and VACO levels to address the concerns. Internal quality of care reviews concluded no patients were at risk, the facility's Chief of Logistics has been removed, and its logistics supply system has been operationalized. The DC VAMC has an action plan to address critical staffing shortages and ensure proper monitoring and management of inventory. In the interim VISN and VACO leadership are providing additional resources and support. Staffers asked about the number of critical staff positions that remain open, how long these positions had been unfilled and what strategies VA would use to ensure critical positions are filled quickly. Staffers also asked if the environment of care concerns with inventory storage areas had been resolved and whether the VISN had assessed other facilities within its purview to ensure similar problems were not occurring elsewhere. OIG's interim report notes that in October 2014 an external consultant identified staffing deficiencies in logistics throughout VISN 5 and that in fiscal year 2015 the Network conducted an internal staffing review. Staffers asked whether VA would provide copies of these earlier reports. OCLA agreed to follow up.

*April 18, 2017. Holly Young, DC VAMC Interior Designer, Facilities Management; Pedro Garcia, VISN 5 Capital Asset Manager; Brian Melewski, Capital Management Consultant; and Christiane Rai, Director, Eastern Real Property Region, CFM will speak with staff members from the Maryland Delegation to discuss current construction projects that are ongoing for the state of MD, that have been under the guidance/monitor of the DCVAMC.

1:00 P.M.; LHOB, RM 1732

POC: (b)(6)

Summary: Christian Rai opened the discussion, providing an update for the Charlotte Hall project. She informed the group of the projected lease award date (Dec 18) and projected time for activation (Winter 2019). Holly Young provided updated information regarding the St. Mary's Lexington Park project. She discussed the recent site survey and the projected time line for activation (Summer 2018). Ms. Young also provided information regarding the Rockville-Gaithersburg site which is set for activation, Winter 2017. There was great discussion regarding the Greenbelt CBOC location of which Mr. Garcia stated VA would follow up and provide more clarity on the background and status of the Greenbelt location. Staff members in attendance were very engaged with feedback and questions but genuinely agreed that the intent and purpose of the meeting was to ensure that the construction projects should not be affected due to the current leadership changes at the DCVAMC. Twelve Congressional staff members from the following offices attended the call; Senators Cardin and Van Hollen and Representatives Ruppersberger, Brown, Raskin, Harris, and Hoyer.

***** April 18, 2017. (Tentative). Dr. Lawrie Zephyrin, Acting ADUSH for Community Care; Dr. Regan Crump, ADUSH for Policy and Planning; Dr. Teresa Boyd, VISN 20, Director and Dr. Tom Lynch ADUSH for Clinical Operations discussed VHA's ongoing market and demand analysis to provide care in the community with professional staff members of the SVAC Minority.

3:30 P.M.; Teleconference

POC: (b)(6)

Summary: Drs. Zephyrin, Boyd and Crump took time to explain to SVAC minority professional staff VA's efforts to strategically determine which healthcare services to provide internal to VA versus what can be provided externally in the market place. They further informed staff that VHA is currently in the process of piloting a market and demand analysis in three VHA healthcare markets areas (VISNs 20, 6 and 7) in hopes of developing a model that will be used across the enterprise to aid local leaders with make/buy decisions. Dr. Zephyrin stated that VA would examine such factors as availability of services internal to the VA, services available through other federal healthcare agencies, healthcare services

available external to VA, costs of care, Veterans demographics within the market, their internal and external utilization rates, as well as an examination of current and future trends, just to name a few factors. Finally, VHA staff explained the goal was to complete the analysis no later than July with the implementing the methodology in determining make/buy decisions within the fiscal year. Ideally, the model would then be rule out VHA wide for full utilization the next year. SVAC staff wanted a list of all VA's healthcare markets.

***** April 18, 2017. Dr. Steven Lieberman, Assistant Deputy Under Secretary for Health for Access to Care, Dr. Shereef Elnahal, Assistant Deputy Under Secretary for Health for Quality, Safety, & Value, and Dr. Saurabha Bhatnagar, Deputy Assistant Deputy Under Secretary for Health for Quality, Safety, and Value conducted an informal question and answer session for Congressional staff.

10:00 A.M. - 2:00 P.M.; 189 Russell

POC: (b)(6)

Summary: No summary will be provided for this event.

***** April 18, 2017. Dr. Steven Lieberman, Assistant Deputy Under Secretary for Health for Access to Care, Dr. Shereef Elnahal, Assistant Deputy Under Secretary for Health for Quality, Safety, & Value, and Dr. Saurabha Bhatnagar, Deputy Assistant Deputy Under Secretary for Health for Quality, Safety, and Value conducted an informal question and answer session for Congressional staff.

1:30 - 3:30 P.M.; 2026 Rayburn

POC: (b)(6)

Summary: No summary will be provided for this event.

***** April 18, 2017. Dr. Patricia Dorn, Director, Rehabilitation Research & Development Service; Dr. Leigh Anderson; Chief Medical Officer, VISN 19; had a call with Dahlia Melendrez, SVAC Minority Staff and a Montana researcher about how to become a VA 5/8 researcher.

5:15 P.M.; Teleconference

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

Look Ahead- Wednesday, April 19, 2017

***** April 19, 2017. Christa Shriber, Deputy Chief Counsel, Accreditation Program, will provide SVAC Majority staff with a briefing on attorney/agent/VSO accreditation.

10:00 A.M.; Teleconference

POC: (b)(6)

***** April 19, 2017. Susan Reed, Executive Director, Revenue Operations, VHA, will meet with Jillian Workman, Professional Staff Member, SVAC, to discuss VHA's revenue collection operations.

10:00 A.M.; 418 Russell

POC: (b)(6)

***** April 19, 2017. Dr. Rachel Ramoni, Chief Research and Development Officer will have an introductory meeting with professional staff from HVAC's Subcommittee on Health, and Subcommittee for Oversight and Investigations.

11:00 A.M.; 234 Cannon

POC: (b)(6)

***** April 19, 2017. Representatives of the Board of Veterans Appeals and the Veterans Benefits Administration, as well as staff from the Office of Management, will meet with Senate Veterans Affairs Committee and Senate MilCon/VA Appropriations Committee staff regarding appeals modernization legislation.

2:00 P.M.; 418 Russell

POC: (b)(6)

***** April 19, 2017. Dr. Ben Kigler, Director, Integrated Health Coordinator Center, VHA will provide an update to Senator Sanders's staff on the expansion of the Center for Integrated Healthcare (CIH).

2:30 P.M.; 332 Dirksen

POC: (b)(6)

***** April 19, 2017. Danny Devine, Deputy Director of Policy and Procedures, Compensation Service, VBA; Johnathan Huges, Chief, Compensation Service, VBA and Roberta Lowe, Acting Director, DMC, will brief SVAC minority staff and members of Sen. Tester's staff on VA's debt management and reimbursement process .

4:00 P.M.; Teleconference

POC: (b)(6)

***** April 19, 2017. Jesse Katherine Vazzano, National Director, HUD-VA Supportive Housing

(HUD-VASH), will brief staff from the Senate Committee on Indian Affairs on the Tribal HUD-VASH program.

4:30 P.M.; Teleconference

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

***** April 26, 2017. The HVAC EO Subcommittee will intends to hold a legislative hearing on the agenda set out below. Curtis Coy, Deputy Under Secretary for Economic Opportunity will be representing the VA.

Agenda

- o H.R. 43 - To authorize the use of Post-9/11 Educational Assistance to pursue independent study programs.
- o H.R. 245 - Veterans' Education Equity Act.
- o H.R. 1104 - Veterans To Enhance Studies Through Accessibility Act.
- o H.R. 1112 - Shauna Hill Post p/11 Education Benefits Transferability Act.
- o H.R. 1216 - Protecting Veterans From School Closures Act of 2017
- o H.R. 1331 - Veterans Success on Campus Act of 2017.
- o H.R. 1384 – Reserve Component Benefits Parity Act
- o H.R. 1793 – Veteran Education Priority Enrollment Act of 2017
- o H.R. 1956 - To increase the amounts of educational assistance payable under Survivors' and Dependents' Educational Assistance Program of the Department of Veterans Affairs.
- o H.R. 1989 - Veteran Employment Through Technology Education Courses Act.
- o H.R. 1994 – Vocational Education and Training Enhancement for Reintegration Assistance Now Act
- o H.R. 2099 - GI Bill Fairness Act of 2017.
- o H.R. 2100 - Work-Study for Student Veterans Act.
- o H.R. 2103 - To include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program.
- o Draft Bill - GI Bill Processing Improvement Act.
- o Draft Bill - GI Bill STEM Extension Act of 2017.

- o Draft Bill - To consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of the Department of Veterans Affairs.
- o Draft Bill - To provide for an election requirement and reduction in basic pay for members of the Armed Forces entitled to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program.

10:00 A.M.; Cannon 334

POC: Martin Martinez, 1-6377

***** April 26, 2017. SVAC intends to hold a legislative hearing on the draft agenda set out below. Lead Witness Jennifer S. Lee, M.D., Deputy Under Secretary for Health For Policy and Services, Veterans Health Administration. Accompanied by: Margaret Kabat, National Director, Caregiver Support Program, Veterans Health Administration; Jan Frye, Deputy Assistant Secretary, Office of Acquisition and Logistics, Office of Acquisition, Logistics, and Construction; and James Ruhlman, Assistant Director for Policy & Procedures, Veterans Benefit Administration.

2:30 P.M.; 412 Russell SOB

POC: Joanna Glaze, 1-6439

Tentative Agenda

- ***** S. 23, Biological Implant Tracking and Veteran Safety Act of 2017 (Cassidy, Tester)
- ***** S. 112, Creating a Reliable Environment for Veterans' Dependents Act (Heller, Murray)
- ***** S. 324, State Veterans Home Adult Day Health Care Improvement Act (Hatch/Hirono, Boozman, Heller, Tillis)
- ***** S. 543, Performance Accountability and Contractor Transparency Act of 2017 (Tester, Murray, Manchin)
- ***** S. 591, Military and Veteran Caregivers Services Improvement Act of 2017 (Murray, Tester, Sanders, Brown, Blumenthal, Hirono, Manchin)
- ***** S. 609, Chiropractic Care Available to All Veterans Act of 2017 (Moran, Tester, Blumenthal, Brown)
- ***** S. 681, Deborah Sampson Act (Tester/Boozman, Murray, Blumenthal, Brown)
- ***** S. 764, Veterans Education Priority Enrollment Act of 2017 (Brown, Tillis)
- ***** S. 784, Veterans' Compensation Cost-of-Living Adjustment Act of 2017 (Isakson/Tester)
- ***** S. 804, Women Veterans Access to Quality Care Act (Heller)
- ***** S. 899, Serving our Rural Veterans Act (Sullivan, Tester)
- ***** S. ___, Veteran Partners' Efforts to Enhance Reintegration Act (Blumenthal)

***** S. ____, Department of Veterans Affairs Veteran Transition Improvement Act (Hirono)

***** April 26, 2017. The Senate Homeland Security and Governmental Affairs Committee intends to hold a hearing on construction of VA medical facilities.

10:00 A.M., 342 Dirksen.

POC: (b)(6)

***** April 27, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's suicide prevention efforts.

Time 10:30 A.M.; Location Dirksen 124

POC: Office of Management (b)(6)

Testimony Status: in development

***** May 2, 2017 (tentative). HVAC intends to hold a legislative hearing on appeals modernization legislation. VA has not received an invitation nor a draft bill. VA witnesses have not been established.

Time TBD.; Location TBD

POC: (b)(6)

***** May 3, 2017. The House Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's FY2018 budget.

Time 10:00 A.M.; Location Rayburn 2359

POC: Office of Management (b)(6)

Testimony Status: in development

***** May 3, 2017. Senate Committee on Indian Affairs will host a hearing on the Tribal U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program.

2:30 P.M., 838 Hart Senate Office Building

POC: (b)(6)

***** May 4, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on telehealth/telemedicine.

Time TBD.; Location TBD

POC: Office of Management

Testimony Status: in development

***** May 10, 2017. SVAC will have an oversight hearing on VA's Choice Program and the Future of Choice and care in the community. The committee has asked Secretary Shulkin to be VA's lead witness.

2:30 P.M., 418 Russell Senate Office Building

POC: (b)(6)

***** May 11, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on the Veterans Choice Program and the future of non-VA care after that program ends.

Time 10:30am Location Dirksen 124

POC: Office of Management (b)(6)

Testimony Status: in development

***** May 24, 2017. (tentative). HVAC intends to hold a hearing on VA's FY2018 budget request.

Time and Location TBD

POC: Office of Management

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Bergman

Jack

MI

Meeting

4/27/2017

VA Priorities Rescheduled from 3/15

Rep

Mast

Brian

FL

Meeting

4/27/2017

Meet & Greet

Rep

Sablan

Gregorio

NMI

Meeting

4/27/2017

Access to Care in the Northern Marianas Islands

HVAC Minority Member Retreat

Meeting

5/1/2017

VA Priorities - Armed Forces Retirement Home (Washington, DC)

Rep

Arrington

Jodey

TX

Meeting

4/27/2017

VA Priorities – Proactive

Chair Miller Portrait Unveiling

Reception

5/3/2017

Rep

Thompson

Mike

CA

Meeting

5/3/2017

Military Veteran Caucus

Rep

Kuster

Ann McClane

NH

Meeting

5/3/2017

Womens Caucus

Sen

Sanders

Bernie

VT

Meeting

3/6/2017

5/4/2017

Privatization, Choice Reshedule from 3/23 and 4/6

GI Film Festival

Reception

5/24/2017

Rep

Brownley

Julia

CA

Meeting

3/28/2017

VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Kihuen

Ruben

NV

Meeting

4/4/2017

Closure of Ely, NV Clinic

Owner: (b)(6) (b)(6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: image001 <extracted>
Last Modified: Tue Apr 18 16:23:12 CDT 2017

This document contains proprietary information and should not be released, in whole or in part, to non -VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or competing Member offices that should not be shared with other congressional entities

Owner: (b)(6) (b)(6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: image002.png
Last Modified: Tue Apr 18 16:23:12 CDT 2017

Page 002 of 03
Printed Item 63 (Attachments 2 of 3)
This information should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or competing Member offices that should not be shared with other entities.
Page 003 of 03

Owner: (b)(6) (b)(6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: Stand up -April 19.docx
Last Modified: Tue Apr 18 16:23:12 CDT 2017

FOR INTERNAL USE ONLY

Secretary's Morning Report
Prepared by the Office of Congressional & Legislative Affairs
Wednesday, April 19, 2017

This document contains proprietary information and should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or **competing** Member offices that should not be shared with other congressional entities

Hot Issues

None

Emerging

None

Congressional Letters and Meeting Requests Received

April 17, 2017. Chairman Jack Bergman (HVAC O&I) requested Excel spreadsheets regarding logistics service purchase at the DC VAMC.

- Received April 18, 2017; VAIQ 7789852.

April 17, 2017. Reps. Sam Graves (R-GA) and Emanuel Cleaver (D-MO) inquired in VA's plan for increasing women's health services at VA facilities.

- Received April 18, 2017; VAIQ 7789848

Tuesday, April 18, 2017 Events

April 17, 2017. Mr. Lawrence Connell, Director at the Department of Veterans Affairs (VA) Medical Center in Washington, D.C. and Mr. Joseph Williams, Network Director VISN 5, conducted a conference call update with staffers from the 4 Corners and Member Offices from DC, Maryland and Virginia.

4:00 P.M.; Teleconference

POC: (b)(6)

Summary: Majority and Minority staffers from HVAC and SVAC as well as personal staff from interested Member offices in the DC VA Medical Center's catchment area and elsewhere were on line. This was a follow up to the call Secretary Shulkin hosted on Thursday, April 13, after release of the Office of Inspector General (OIG) Health Care Inspection Interim Report. Mr. Connell, provided an overview describing the events that led to the OIG investigation. The facility Director detailed specific actions taken at the facility, VISN and VACO levels to address the concerns. Internal quality of care reviews concluded no patients were at risk, the facility's Chief of Logistics has been removed, and its logistics supply system has been operationalized. The DC VAMC has an action plan to address critical staffing shortages and ensure proper monitoring and management of inventory. In the interim VISN and VACO leadership are providing additional resources and support. Staffers asked about the number of critical staff positions that remain open, how long these positions had been unfilled and what strategies VA would use to ensure critical positions are filled quickly. Staffers also

FOR INTERNAL USE ONLY

asked if the environment of care concerns with inventory storage areas had been resolved and whether the VISN had assessed other facilities within its purview to ensure similar problems were not occurring elsewhere. OIG's interim report notes that in October 2014 an external consultant identified staffing deficiencies in logistics throughout VISN 5 and that in fiscal year 2015 the Network conducted an internal staffing review. Staffers asked whether VA would provide copies of these earlier reports. OCLA agreed to follow up.

April 18, 2017. Holly Young, DC VAMC Interior Designer, Facilities Management; Pedro Garcia, VISN 5 Capital Asset Manager; Brian Melewski, Capital Management Consultant; and Christiane Rai, Director, Eastern Real Property Region, CFM will speak with staff members from the Maryland Delegation to discuss current construction projects that are ongoing for the state of MD, that have been under the guidance/monitor of the DCVAMC.

1:00 P.M.; LHOB, RM 1732

POC: (b)(6)

Summary: Christian Rai opened the discussion, providing an update for the Charlotte Hall project. She informed the group of the projected lease award date (Dec 18) and projected time for activation (Winter 2019). Holly Young provided updated information regarding the St. Mary's Lexington Park project. She discussed the recent site survey and the projected time line for activation (Summer 2018). Ms. Young also provided information regarding the Rockville-Gaithersburg site which is set for activation, Winter 2017. There was great discussion regarding the Greenbelt CBOC location of which Mr. Garcia stated VA would follow up and provide more clarity on the background and status of the Greenbelt location. Staff members in attendance were very engaged with feedback and questions but genuinely agreed that the intent and purpose of the meeting was to ensure that the construction projects should not be affected due to the current leadership changes at the DCVAMC. Twelve Congressional staff members from the following offices attended the call; Senators Cardin and Van Hollen and Representatives Ruppersberger, Brown, Raskin, Harris, and Hoyer.

April 18, 2017. (Tentative). Dr. Lawrie Zephyrin, Acting ADUSH for Community Care; Dr. Regan Crump, ADUSH for Policy and Planning; Dr. Teresa Boyd, VISN 20, Director and Dr. Tom Lynch ADUSH for Clinical Operations discussed VHA's ongoing market and demand analysis to provide care in the community with professional staff members of the SVAC Minority.

3:30 P.M.; Teleconference

POC: (b)(6)

Summary: Drs. Zephyrin, Boyd and Crump took time to explain to SVAC minority professional staff VA's efforts to strategically determine which healthcare services to provide internal to VA versus what can be provided externally in the market place. They further informed staff that VHA is currently in the process of piloting a market and demand analysis in three VHA healthcare markets areas (VISNs 20, 6 and 7) in hopes of developing a model that will be used across the enterprise to aid local leaders with make/buy decisions. Dr. Zephyrin stated that VA would examine such factors as availability of services internal to the VA, services available through other federal healthcare agencies, healthcare services available external to VA, costs of care, Veterans demographics within the market, their internal and external utilization rates, as well as an examination of current and future trends, just to name a few factors. Finally, VHA staff explained the goal was to complete the analysis no later than July

FOR INTERNAL USE ONLY

with the implementing the methodology in determining make/buy decisions within the fiscal year. Ideally, the model would then be rule out VHA wide for full utilization the next year. SVAC staff wanted a list of all VA's healthcare markets.

April 18, 2017. Dr. Steven Lieberman, Assistant Deputy Under Secretary for Health for Access to Care, Dr. Shereef Elnahal, Assistant Deputy Under Secretary for Health for Quality, Safety, & Value, and Dr. Saurabha Bhatnagar, Deputy Assistant Deputy Under Secretary for Health for Quality, Safety, and Value conducted an informal question and answer session for Congressional staff.

10:00 A.M. - 2:00 P.M.; 189 Russell

POC: (b)(6)

Summary: No summary will be provided for this event.

April 18, 2017. Dr. Steven Lieberman, Assistant Deputy Under Secretary for Health for Access to Care, Dr. Shereef Elnahal, Assistant Deputy Under Secretary for Health for Quality, Safety, & Value, and Dr. Saurabha Bhatnagar, Deputy Assistant Deputy Under Secretary for Health for Quality, Safety, and Value conducted an informal question and answer session for Congressional staff.

1:30 - 3:30 P.M.; 2026 Rayburn

POC: (b)(6)

Summary: No summary will be provided for this event.

April 18, 2017. Dr. Patricia Dorn, Director, Rehabilitation Research & Development Service; Dr. Leigh Anderson; Chief Medical Officer, VISN 19; had a call with Dahlia Melendrez, SVAC Minority Staff and a Montana researcher about how to become a VA 5/8 researcher.

5:15 P.M.; Teleconference

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

Look Ahead- Wednesday, April 19, 2017
--

April 19, 2017. Christa Shriber, Deputy Chief Counsel, Accreditation Program, will provide SVAC Majority staff with a briefing on attorney/agent/VSO accreditation.

10:00 A.M.; Teleconference

POC: (b)(6)

April 19, 2017. Susan Reed, Executive Director, Revenue Operations, VHA, will meet with Jillian Workman, Professional Staff Member, SVAC, to discuss VHA's revenue collection operations.

10:00 A.M.; 418 Russell

POC: (b)(6)

April 19, 2017. Dr. Rachel Ramoni, Chief Research and Development Officer will have an introductory meeting with professional staff from HVAC's Subcommittee on Health, and Subcommittee for Oversight and Investigations.

11:00 A.M.; 234 Cannon

POC: (b)(6)

FOR INTERNAL USE ONLY

April 19, 2017. Representatives of the Board of Veterans Appeals and the Veterans Benefits Administration, as well as staff from the Office of Management, will meet with Senate Veterans Affairs Committee and Senate MilCon/VA Appropriations Committee staff regarding appeals modernization legislation.

2:00 P.M.; 418 Russell

POC: (b)(6)

April 19, 2017. Dr. Ben Kigler, Director, Integrated Health Coordinator Center, VHA will provide an update to Senator Sanders's staff on the expansion of the Center for Integrated Healthcare (CIH).

2:30 P.M.; 332 Dirksen

POC: (b)(6)

April 19, 2017. Danny Devine, Deputy Director of Policy and Procedures, Compensation Service, VBA; Johnathan Huges, Chief, Compensation Service, VBA and Roberta Lowe, Acting Director, DMC, will brief SVAC minority staff and members of Sen. Tester's staff on VA's debt management and reimbursement process .

4:00 P.M.; Teleconference

POC: (b)(6)

April 19, 2017. Jesse Katherine Vazzano, National Director, HUD-VA Supportive Housing (HUD-VASH), will brief staff from the Senate Committee on Indian Affairs on the Tribal HUD-VASH program.

4:30 P.M.; Teleconference

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

April 26, 2017. The HVAC EO Subcommittee will intends to hold a legislative hearing on the agenda set out below. Curtis Coy, Deputy Under Secretary for Economic Opportunity will be representing the VA.

Agenda

- **H.R. 43** - To authorize the use of Post-9/11 Educational Assistance to pursue independent study programs.
- **H.R. 245** - Veterans' Education Equity Act.
- **H.R. 1104** - Veterans To Enhance Studies Through Accessibility Act.
- **H.R. 1112** - Shauna Hill Post p/11 Education Benefits Transferability Act.
- **H.R. 1216** - Protecting Veterans From School Closures Act of 2017
- **H.R. 1331** - Veterans Success on Campus Act of 2017.
- **H.R. 1384** – Reserve Component Benefits Parity Act
- **H.R. 1793** – Veteran Education Priority Enrollment Act of 2017
- **H.R. 1956** - To increase the amounts of educational assistance payable under Survivors' and Dependents' Educational Assistance Program of the Department of Veterans Affairs.
- **H.R. 1989** - Veteran Employment Through Technology Education Courses Act.

FOR INTERNAL USE ONLY

- **H.R. 1994** – Vocational Education and Training Enhancement for Reintegration Assistance Now Act
- **H.R. 2099** - GI Bill Fairness Act of 2017.
- **H.R. 2100** - Work-Study for Student Veterans Act.
- **H.R. 2103** - To include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program.
- **Draft Bill** - GI Bill Processing Improvement Act.
- **Draft Bill** - GI Bill STEM Extension Act of 2017.
- **Draft Bill** - To consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of the Department of Veterans Affairs.
- **Draft Bill** - To provide for an election requirement and reduction in basic pay for members of the Armed Forces entitled to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program.

10:00 A.M.; Cannon 334

POC: (b)(6)

April 26, 2017. SVAC intends to hold a legislative hearing on the draft agenda set out below.
Lead Witness Jennifer S. Lee, M.D., Deputy Under Secretary for Health For Policy and Services, Veterans Health Administration. Accompanied by: Margaret Kabat, National Director, Caregiver Support Program, Veterans Health Administration; Jan Frye, Deputy Assistant Secretary, Office of Acquisition and Logistics, Office of Acquisition, Logistics, and Construction; and James Ruhlman, Assistant Director for Policy & Procedures, Veterans Benefit Administration.

2:30 P.M.; 412 Russell SOB

POC: (b)(6)

Tentative Agenda

- S. 23, Biological Implant Tracking and Veteran Safety Act of 2017 (Cassidy, Tester)
- S. 112, Creating a Reliable Environment for Veterans' Dependents Act (Heller, Murray)
- S. 324, State Veterans Home Adult Day Health Care Improvement Act (Hatch/Hirono, Boozman, Heller, Tillis)
- S. 543, Performance Accountability and Contractor Transparency Act of 2017 (Tester, Murray, Manchin)
- S. 591, Military and Veteran Caregivers Services Improvement Act of 2017 (Murray, Tester, Sanders, Brown, Blumenthal, Hirono, Manchin)
- S. 609, Chiropractic Care Available to All Veterans Act of 2017 (Moran, Tester, Blumenthal, Brown)
- S. 681, Deborah Sampson Act (Tester/Boozman, Murray, Blumenthal, Brown)
- S. 764, Veterans Education Priority Enrollment Act of 2017 (Brown, Tillis)
- S. 784, Veterans' Compensation Cost-of-Living Adjustment Act of 2017 (Isakson/Tester)
- S. 804, Women Veterans Access to Quality Care Act (Heller)
- S. 899, Serving our Rural Veterans Act (Sullivan, Tester)
- S. ____, Veteran Partners' Efforts to Enhance Reintegration Act (Blumenthal)

FOR INTERNAL USE ONLY

S. ____, Department of Veterans Affairs Veteran Transition Improvement Act
(Hirono)

April 26, 2017. The Senate Homeland Security and Governmental Affairs Committee intends to hold a hearing on construction of VA medical facilities.

10:00 A.M., 342 Dirksen.

POC: (b)(6)

April 27, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's suicide prevention efforts.

Time 10:30 A.M.; Location Dirksen 124

POC: Office of Management, (b)(6)

Testimony Status: in development

May 2, 2017 (tentative). HVAC intends to hold a legislative hearing on appeals modernization legislation. VA has not received an invitation nor a draft bill. VA witnesses have not been established.

Time TBD.; Location TBD

POC: (b)(6)

May 3, 2017. The House Appropriations VA/MilCon Subcommittee intends to hold a hearing on VA's FY2018 budget.

Time 10:00 A.M.; Location Rayburn 2359

POC: Office of Management, (b)(6)

Testimony Status: in development

May 3, 2017. Senate Committee on Indian Affairs will host a hearing on the Tribal U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) Program.

2:30 P.M., 838 Hart Senate Office Building

POC: (b)(6)

May 4, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on telehealth/telemedicine.

Time TBD.; Location TBD

POC: Office of Management

Testimony Status: in development

May 10, 2017. SVAC will have an oversight hearing on VA's Choice Program and the Future of Choice and care in the community. The committee has asked Secretary Shulkin to be VA's lead witness.

2:30 P.M., 418 Russell Senate Office Building

POC: (b)(6)

May 11, 2017. The Senate Appropriations VA/MilCon Subcommittee intends to hold a hearing on the Veterans Choice Program and the future of non-VA care after that program ends.

Time 10:30am Location Dirksen 124

POC: Office of Management, (b)(6)

FOR INTERNAL USE ONLY

Testimony Status: in development

May 24, 2017. (tentative). HVAC intends to hold a hearing on VA's FY2018 budget request.

Time and Location TBD

POC: Office of Management

Member Engagement Requests for Senior Leaders

Sen/Rep	Last Name	First Name	State	Type of Engagement	Received	Date Scheduled	Topic
Rep	Bergman	Jack	MI	Meeting		4/27/2017	VA Priorities Rescheduled from 3/15
Rep	Mast	Brian	FL	Meeting		4/27/2017	Meet & Greet
Rep	Sablan	Gregorio	NMI	Meeting		4/27/2017	Access to Care in the Northern Marianas Islands
	HVAC Minority Member Retreat			Meeting		5/1/2017	VA Priorities - Armed Forces Retirement Home (Washington, DC)
Rep	Arrington	Jodey	TX	Meeting		4/27/2017	VA Priorities – Proactive
	Chair Miller Portrait Unveiling			Reception		5/3/2017	
Rep	Thompson	Mike	CA	Meeting		5/3/2017	Military Veteran Caucus
Rep	Kuster	Ann McCrane	NH	Meeting		5/3/2017	Womens Caucus
Sen	Sanders	Bernie	VT	Meeting	3/6/2017	5/4/2017	Privatization, Choice Reschedule from 3/23 and 4/6
	GI Film Festival			Reception		5/24/2017	
Rep	Brownley	Julia	CA	Meeting	3/28/2017		VA Priorities - Reschedule from 3/15 - Reschedule again due to HVAC Hearing Conflict
Sen	Sullivan	Dan	AK	Travel	2/1/2017		SecVA State Visit Request
Sen	Tester	Jon	MT	Travel	2/1/2017		SecVA State Visit Request
Sen	Manchin	Joe	WV	Travel	2/1/2017		SecVA State Visit Request
Sen	Daines	Steve	MT	Travel	1/25/2017		Ft Harrison
Rep	Esty	Elizabeth	CT	Travel	3/15/2017		Newington & Farmington, CT
Rep	Kuster	Ann	NH	Travel	3/15/2017		Nashua, NH Homelessness/Suicide

FOR INTERNAL USE ONLY

		McClane					
Rep	Bacon	Don	NE	Meeting	3/23/2017		Omaha Ambulatory Care Center
Rep	Kihuen	Ruben	NV	Meeting	4/4/2017		Closure of Ely, NV Clinic

From: (b)(6) </o=va/ou=exchange
administrative group
(fydibohf23spdlt)/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report 7/19/17
Date: Tue Jul 18 2017 16:50:10 CDT
Attachments: image001
image002.png
Stand up -July 19.docx

All,

Attached is the Morning Report for Wednesday, July 19, 2017. This document is for internal use only.

(b)(6)

Program Analyst, Corporate Enterprise
Office of Congressional and Legislative Affairs
Department of Veterans Affairs
810 Vermont Ave., NW
Desk: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Wednesday, July 19, 2017

Hot Issues

***** None

Emerging

***** None

Congressional Letters and Meeting Requests Received

***** July 14, 2017. Seven Members of Congress requested that VA accelerate its hiring of licensed Naturopathic doctors.

- o Received July 18, 2017; VAIQ 7815297.

***** June 15, 2017. Rep. Peter Visclosky (R-IN) expressed concern regarding animal experimentation.

- o Received July 18, 2017; VAIQ 7815314.

Tuesday, July 18, 2017 Events

***** July 17, 2017. VHA leadership provided an update to Four Corners professional staff and personal staff from the NH delegation on the issues surrounding the allegation of substandard care at the Manchester, NH VAMC.

3:30 P.M.; Conference call

POC: (b)(6)

Summary: Dr. Miguel LaPuz, Acting VA Principal Deputy Under Secretary for Health, lead the discussion for VHA by laying out VHA's original involvement with the Boston Globe's request for information relating to Manchester VAMC. Boston Globe had asked for information on four areas of concern: unsanitary operating room conditions, whistleblowers raising quality issues in Neurosurgical and spinal cord injury patients, Stained instruments in outpatient surgery clinic, and Choice referral difficulties. Many of these issues were brought up by OSC and reviewed by OMI previously. OMI had

focused on allegations brought to them by OSC: SCI and neurosurgical referrals, unsanitary operating room conditions, and a clinician copying and pasting information from one patient's EHR to a different patient's record. Dr. LaPuz also informed the staff that VHA has two ongoing reviews looking into: 1. OMI's review of other issues found in the article and separate items that were brought up to OSC that have not yet been reviewed and 2. Office of Accountability and Whistleblower Protections looking into actions of VAMC Leadership. Currently, additional VHA leadership are onsite and meeting with staff, the whistleblowers and external stakeholders. The acting Medical Center Director is onsite as well coming from WRJ. OSC's report is still pending.

***** July 17, 2017. Ms. Mary Glenn, Deputy Director of Contract Exams, VBA; and

Ms. Laurine Carson, Assistant Director for Procedures, VBA provided HVAC DAMA Ranking Member, Elizabeth Esty, a briefing on Standards for ordering a disability exam, and the international examination process.

4:00 P.M.; 221 Cannon House Office Building

POC: (b)(6)

Summary: The purpose of this briefing was to provide Ranking Member Esty with a general understanding of the standards for ordering a disability exam prior to the July 18th Roundtable on disability exams. The Ranking Member expressed her gratitude to VA staff for taking the time to provide an overview on the subject matter. The Ranking Member inquired about the training of contracted examiners; VA's tracking mechanism to ensure contracted examiners are taking prescribed training; the Veteran no-show rate for both VHA and contracted examiners; and adequacy reviews of disability exams. The Ranking Member expressed her opposition to privatizing disability exams, and asked VA officials to come to her in the future if VA considers privatization as an option. Due to the Ranking Member's schedule limitations, the international examination process was not discussed.

***** July 17, 2017. VBA Director of Education Service Robert Worley provided a briefing to HVAC EO Chairman Arrington on educational institution performance measures.

4:30 PM; Conference Call

POC: (b)(6)

Summary: VBA Education Service staff provided an unplanned and friendly briefing to HVAC EO Chairman Arrington and HVAC EO staff. Chairman Arrington discussed performance measures for educational institutions and his preference for letting Veterans decide which schools are qualified for receiving GI Bill funds. Chairman Arrington also stressed the need for better school outcome measures and asked for additional information regarding current VA performance metrics for GI Bill institutions. VBA staff relayed how the approach outlined by Chairman Arrington is different from current practice and also discussed recent changes in available data resulting from PL 114-315

***** July 18, 2017: Ms. Renee Oshinski, VISN 12 Network Director, met with Senator 's staff to provide an update of the Zablocki VAMC in Madison, WI.

1:30; Hart 507

POC: (b)(6)

Summary: VISN Director Renee Oshinski met with Ken Reidy of Senator Baldwin's staff and provided updates on the Zablocki domiciliary and grant per diem programs (including newly implemented safety changes). She ensured Mr. Reidy that the Department remains committed to provide housing for all Veterans. The conversation transitioned into updates on personnel actions at the Madison facility to which a status report was provided. Mr. Reidy relayed the Senator's plan to travel to the Tomah VAMC on July 29th to attend an event related to the CARA implementation and communicated the Senator's compliments of the facility and the positive stories that are routinely shared.

***** July 18, 2017. HVAC DAMA held a Roundtable on Disability Examinations.

Witnesses: Beth Murphy, Director, Compensation Service, VBA; Mary Glenn, Deputy Director for Contract Exams, Compensation Service, VBA; and Patricia Murray, Chief Officer, Office of Disability and Medical Assessment, VHA

2:00 P.M.; 334 Cannon

POC: (b)(6)

Summary: The roundtable was constructive in nature where Veteran Service Organizations, Contracted Exam Vendors (QTC, VES), VA officials, and Members of Congress discussed how to increase the quality of disability claims review through process improvement. Common themes discussed were: communication between VA and QTC and VES; how to ensure examiners review Veterans' lay-statements; ambiguity within DBQs; the format and structure in which exam requests are sent to QTC; and how VA determines the distribution of a claim to either a VHA examiner or a contact examiner. Both Vendors spoke positively of their relationship with VA.

***** July 18, 2017. The House Committee on Veterans Affairs Chairman, Rep. Phil Roe, held a roundtable discussion on the opioid crisis.

10:00 A.M.; 334 Cannon

POC: (b)(6)

Summary: Dr. Laurence J. Meyer, Chief Officer of Specialty Care Services, opened by sharing information on what the VA has done to address opioid use and misuse including the Opioid Safety Initiative. Ranking Member Walz asked what needed to be done to stop opioid over prescribing. Dr. John Renner stated medical schools needed to change their curriculum to include pain management and opioid prescribing as was done in Massachusetts. Dr. Krebs added that she didn't receive any pain management training until she was employed with VA. Chairman Roe M.D. and Dr. Krebs both agreed that pain should not be considered a 5th vital sign. Rep. Correa was curious to know VA's stance on prescribing medical marijuana to manage pain. Dr. Meyer reiterated the Secretary comments saying we will not withhold treatment or benefits from Veterans who use marijuana, that more medical research is needed, but ultimately VA will implement the law. Chairman Roe added there is little research to support that marijuana is a healthy alternative to opioids. Congresswoman Brownley was concerned with VA's process for evaluating the efficacy of alternative therapies. Dr. Meyer stated that in accordance with the Comprehensive Addiction and Recovery Act (CARA), VA is in the process of expanding research, education and delivery of complementary medicine across all VISNs. Congressman Bergmann asked about the difference between the rates that opioids are prescribed at the VA compared to private providers. Dr. Meyer stated the number of Veterans prescribed opioids has decreased from 17.2% to 11.1 % (a 33% decrease) within VA, while the US average for adults is roughly 20%. Dr. Meyer also noted that Veterans who use Choice are prescribed opioids at a higher

rate than if they were to stay in the VA system. In closing, Chairman Roe expressed his satisfaction with the roundtable.

***** July 18, 2017. The Acting USB and SME held a teleconference with Rep. Brownley to discuss the topic of overpayments as related to the GI Bill.

11:45 A.M.; Teleconference.

POC: (b)(6)

Summary: Summary will be provided tomorrow.

***** July 18, 2017. CLS participated in a CRS District Caseworker seminar and provide a basic casework briefing.

1:30 P.M.; Madison Building

POC: (b)(6)

Summary: Due to the timing of event a summary will be provided tomorrow.

***** July 18, 2017. (Postponed – June 28, 2017 and July 7, 2017). Cynthia Heaton, Chief, Health Administration Service, Deputy Director of Claims Adjudication and Reimbursement; held a follow up meeting with Rep. Mike Thompson's (D-CA-05) Staff and the Director for Admitting and Patient Financial Services (APFS) for Sonoma Hospital to discuss the resolution of aging accounts receivable.

4:00 P.M.; Teleconference

POC: (b)(6)

Summary: Due to the timing of event a summary will be provided tomorrow.

Look Ahead- Wednesday, July 19, 2017

***** July 19, 2017. Sallie Houser-Hanfelter, Director, Denver VAMC and Ralph Gigliotti, VISN 19 Network Director, will meet with the Denver, Colorado delegation to discuss activation of the Denver VA facility.

9:00 A.M.; Teleconference

POC: (b)(6)

***** July 19, 2017: Mr. Ed Litvin, Director, OCAMES, will discuss the status of the proposed Veterans home in Flagstaff, AZ.

10:00 A.M.; Teleconference

POC: (b)(6)

***** July 19, 2017. SVAC will convene a hearing to consider the pending nominations of Tom Bowman to be Deputy Secretary of the Department of Veterans Affairs, Jim Byrne to be General Counsel of the Department of Veterans Affairs, Brooks Tucker to be Assistant Secretary of Congressional and Legislative Affairs of the Department of Veterans Affairs, and possibly others to be named later.

Witnesses: Tom Bowman, Jim Byrne, Brooks Tucker, and possibly others to be named later

2:30 P.M.; 418 Russell

POC: (b)(6)

***** July 19-20, 2017. Ms. Jennifer Gutowski, Director of VA Pacific Islands Health Care System, will meet with members of congress within her catchment area. She will also have a brief discussion with HVAC staff. The meetings will be introductory in nature, and she will share some of her insights resulting in the listening sessions she has held since her new appointment as Director.

10:00 A.M. - 2:00 P.M.; Capitol Hill

POCs: (b)(6)

***** July 19, 2017. Jennifer Gutowski, Director of VA Pacific Islands Health Care System, will meet with Delegate Radewagen to discuss VA care in American Samoa.

12:00 P.M.; 1339 Longworth

POC: (b)(6)

***** July 19, 2017. Clifford A. Smith, Deputy Director of Office of Mental Health and Suicide Prevention, will brief Democratic District Directors on implementation of VA's new OTH policy so local congressional offices can better assist constituents with casework.

1:00 P.M.; Teleconference

POC: (b)(6)

***** July 19, 2017. Jennifer Gutowski, Director of VA Pacific Islands Health Care System, will meet with Senator Hirono to discuss VA care in Hawaii.

2:00 P.M.; 330 Hart

POC: (b)(6)

***** July 19, 2017. (Postponed - May 19, 2017 and June 29, 2017). Jeff London, Director, VA Home Loan Guaranty Service, and Gerald Kifer, Supervisory Appraiser, VA Home Loan Guaranty Service, will brief HVAC Rep. Jim Banks (R-IN-03) on the general regulatory process and specific regulations affecting the VA Home Loan Program.

2:30 P.M.; 509 Cannon

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

***** July 25, 2017. HVAC Subcommittee on Disability Assistance and Memorial Affairs will hold a hearing on VBA's processing of claims for benefits based on Post-Traumatic Stress Disorder.

10:30 A.M.; 334 Cannon

Witness: TBD

POC: (b)(6)

***** July 25, 2017. The Committee on Veterans' Affairs Subcommittee on Health will host a roundtable discussion on telehealth in the VA healthcare system. During this roundtable, the Subcommittee will examine the use and effectiveness of telehealth techniques across the VA healthcare system as well as VA's response to challenges such as a lack of reimbursement structure for telehealth appointments and ambiguity surrounding VA providers' ability to practice telehealth.

2:00 P.M.; 334 Cannon

POC: (b)(6)

***** August 10, 2017. Field Hearing on Access to Care and Care in the Community both in rural areas. The hearing will be held in Duluth, MN, with the full committee. This hearing was at the request of the minority. It is a possibility Chairman Roe will not be in attendance, so another member of the majority will serve as the Chairman. They are requesting Dr. Yehia, someone from the Office of Rural Health, and a local witness (MCD).

Time and Location TBD

POC: (b)(6)

***** TBD. The HVAC EO Subcommittee will hold a legislative hearing on the agenda set out below.

Agenda

- ***** H.R. 43 - To authorize the use of Post-9/11 Educational Assistance to pursue independent study programs.
- ***** H.R. 245 - Veterans' Education Equity Act.
- ***** H.R. 1104 - Veterans To Enhance Studies Through Accessibility Act.
- ***** H.R. 1112 - Shauna Hill Post-9/11 Education Benefits Transferability Act.
- ***** H.R. 1216 - Protecting Veterans from School Closures Act of 2017.
- ***** H.R. 1331 - Veterans Success on Campus Act of 2017.
- ***** H.R. 1384 - Reserve Component Benefits Parity Act.
- ***** H.R. 1793 - Veteran Education Priority Enrollment Act of 2017.
- ***** H.R. 1956 - To increase the amounts of educational assistance payable under Survivors' and Dependents' Educational Assistance Program of the Department of Veterans Affairs.
- ***** H.R. 1989 - Veteran Employment Through Technology Education Courses Act.
- ***** H.R. 1994 - Vocational Education and Training Enhancement for Reintegration Assistance Now Act.
- ***** H.R. 2099 - GI Bill Fairness Act of 2017 Act.
- ***** H.R. 2100 - Work Study for Student Veterans Act.
- ***** H.R. 2103 - To include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program.
- ***** H.R. 2108 - GI Bill STEM Extension Act of 2017.
- ***** H.R. 2257 - To consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of the Department of Veterans Affairs.
- ***** Draft Bill - GI Bill Processing Improvement Act.
- ***** Draft Bill To provide for an election requirement and reduction in basic pay for members of the Armed Forces entitled to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program.

Witness: Curtis Coy, Deputy Under Secretary for Economic Opportunity.

10:00 A.M.; 334 Cannon

POC: (b)(6)

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Sen

Tester

Jon

MT

Travel

8/24/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

8/24/2017

Ft Harrison, MT

Rep

Bishop

Sanford

GA

Speech

9/22/2017

VA health care system for 2040, specifically for women and minorities

Sen

Rubio

Marco

FL

Meeting

5/4/2017

Accountability Legislation

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide White River Junction - Opioid

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Moulton

Seth

MA

Meeting

5/10/2017

Priorities

Rep

Arrington

Jodey

TX

Meeting

4/5/2017

VA Priorities – Proactive

Rep

Lieu

Ted

CA

Travel

5/30/2017

West LA

Rep

Gonzales-Colon

Jennifer

PR

Meeting

6/7/2017

Puerto Rico Concerns

Rep

Norcross

Donald

NJ

Meeting

6/8/2017

Constituent

Sen

Tillis/Tester

NC/MT

Meeting

6/20/2017

Choice

Rep

Rooney

Francis

FL

Travel

6/23/2017

Rep

Davis/Bost

Rodney/ Mike

IL

Travel

6/30/2017

Forum

Owner: (b)(6) (b)(6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: image001 <extracted>
Last Modified: Tue Jul 18 16:50:10 CDT 2017

This document contains proprietary information and should not be released, in whole or in part, to non -VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or competing Member offices that should not be shared with other congressional entities

Owner: (b)(6) (b)(6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: image002.png
Last Modified: Tue Jul 18 16:50:10 CDT 2017

Page 002 of 03
This document contains information that should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or competing Member offices that should not be shared with other entities.

Page 003 of 03

Owner: (b)(6) (b)(6) </o=va/ou=exchange administrative group (fydibohf23spdlt)
/cn=recipients/cn=(b)(6)
Filename: Stand up -July 19.docx
Last Modified: Tue Jul 18 16:50:10 CDT 2017

FOR INTERNAL USE ONLY

Secretary's Morning Report
Prepared by the Office of Congressional & Legislative Affairs
Wednesday, July 19, 2017

This document contains proprietary information and should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or **competing** Member offices that should not be shared with other congressional entities

Hot Issues

None

Emerging

None

Congressional Letters and Meeting Requests Received

July 14, 2017. Seven Members of Congress requested that VA accelerate its hiring of licensed Naturopathic doctors.

- Received July 18, 2017; VAIQ 7815297.

June 15, 2017. Rep. Peter Visclosky (R-IN) expressed concern regarding animal experimentation.

- Received July 18, 2017; VAIQ 7815314.

Tuesday, July 18, 2017 Events

July 17, 2017. VHA leadership provided an update to Four Corners professional staff and personal staff from the NH delegation on the issues surrounding the allegation of substandard care at the Manchester, NH VAMC.

3:30 P.M.: Conference call

POC: (b)(6)

Summary: Dr. Miguel LaPuz, Acting VA Principal Deputy Under Secretary for Health, lead the discussion for VHA by laying out VHA's original involvement with the Boston Globes's request for information relating to Manchester VAMC. Boston Globe had asked for information on four areas of concern: unsanitary operating room conditions, whistleblowers raising quality issues in Neurosurgical and spinal cord injury patients, Stained instruments in outpatient surgery clinic, and Choice referral difficulties. Many of these issues were brought up by OSC and reviewed by OMI previously. OMI had focused on allegations brought to them by OSC: SCI and neurosurgical referrals, unsanitary operating room conditions, and a clinician copying and pasting information from one patient's EHR to a different patient's record. Dr. LaPuz also informed the staff that VHA has two ongoing reviews looking into: 1. OMI's review of other issues found in the article and separate items that were brought up to OSC that have not yet been reviewed and 2. Office of Accountability and Whistleblower Protections looking into actions of VAMC Leadership. Currently, additional VHA leadership are onsite and meeting with staff, the whistleblowers and external stakeholders. The acting Medical Center Director is onsite as well coming from WRJ. OSC's report is still pending.

FOR INTERNAL USE ONLY

July 17, 2017. Ms. Mary Glenn, Deputy Director of Contract Exams, VBA; and Ms. Laurine Carson, Assistant Director for Procedures, VBA provided HVAC DAMA Ranking Member, Elizabeth Esty, a briefing on Standards for ordering a disability exam, and the international examination process.

4:00 P.M.; 221 Cannon House Office Building

POC: (b)(6)

Summary: The purpose of this briefing was to provide Ranking Member Esty with a general understanding of the standards for ordering a disability exam prior to the July 18th Roundtable on disability exams. The Ranking Member expressed her gratitude to VA staff for taking the time to provide an overview on the subject matter. The Ranking Member inquired about the training of contracted examiners; VA's tracking mechanism to ensure contracted examiners are taking prescribed training; the Veteran no-show rate for both VHA and contracted examiners; and adequacy reviews of disability exams. The Ranking Member expressed her opposition to privatizing disability exams, and asked VA officials to come to her in the future if VA considers privatization as an option. Due to the Ranking Member's schedule limitations, the international examination process was not discussed.

July 17, 2017. VBA Director of Education Service Robert Worley provided a briefing to HVAC EO Chairman Arrington on educational institution performance measures.

4:30 PM; Conference Call

POC: (b)(6)

Summary: VBA Education Service staff provided an unplanned and friendly briefing to HVAC EO Chairman Arrington and HVAC EO staff. Chairman Arrington discussed performance measures for educational institutions and his preference for letting Veterans decide which schools are qualified for receiving GI Bill funds. Chairman Arrington also stressed the need for better school outcome measures and asked for additional information regarding current VA performance metrics for GI Bill institutions. VBA staff relayed how the approach outlined by Chairman Arrington is different from current practice and also discussed recent changes in available data resulting from PL 114-315

July 18, 2017: Ms. Renee Oshinski, VISN 12 Network Director, met with Senator 's staff to provide an update of the Zablocki VAMC in Madison, WI.

1:30; Hart 507

POC: (b)(6)

Summary: VISN Director Renee Oshinski met with Ken Reidy of Senator Baldwin's staff and provided updates on the Zablocki domiciliary and grant per diem programs (including newly implemented safety changes). She ensured Mr. Reidy that the Department remains committed to provide housing for all Veterans. The conversation transitioned into updates on personnel actions at the Madison facility to which a status report was provided. Mr. Reidy relayed the Senator's plan to travel to the Tomah VAMC on July 29th to attend an event related to the CARA implementation and communicated the Senator's compliments of the facility and the positive stories that are routinely shared.

July 18, 2017. HVAC DAMA held a Roundtable on Disability Examinations.

Witnesses: Beth Murphy, Director, Compensation Service, VBA; Mary Glenn, Deputy Director for Contract Exams, Compensation Service, VBA; and Patricia Murray, Chief Officer, Office of Disability and Medical Assessment, VHA

2:00 P.M.; 334 Cannon

POC: (b)(6)

FOR INTERNAL USE ONLY

Summary: The roundtable was constructive in nature where Veteran Service Organizations, Contracted Exam Vendors (QTC, VES), VA officials, and Members of Congress discussed how to increase the quality of disability claims review through process improvement. Common themes discussed were: communication between VA and QTC and VES; how to ensure examiners review Veterans' lay-statements; ambiguity within DBQs; the format and structure in which exam requests are sent to QTC; and how VA determines the distribution of a claim to either a VHA examiner or a contract examiner. Both Vendors spoke positively of their relationship with VA.

July 18, 2017. The House Committee on Veterans Affairs Chairman, Rep. Phil Roe, held a roundtable discussion on the opioid crisis.

10:00 A.M.; 334 Cannon

POC: (b)(6)

Summary: Dr. Laurence J. Meyer, Chief Officer of Specialty Care Services, opened by sharing information on what the VA has done to address opioid use and misuse including the Opioid Safety Initiative. Ranking Member Walz asked what needed to be done to stop opioid over prescribing. Dr. John Renner stated medical schools needed to change their curriculum to include pain management and opioid prescribing as was done in Massachusetts. Dr. Krebs added that she didn't receive any pain management training until she was employed with VA. Chairman Roe M.D. and Dr. Krebs both agreed that pain should not be considered a 5th vital sign. Rep. Correa was curious to know VA's stance on prescribing medical marijuana to manage pain. Dr. Meyer reiterated the Secretary comments saying we will not withhold treatment or benefits from Veterans who use marijuana, that more medical research is needed, but ultimately VA will implement the law. Chairman Roe added there is little research to support that marijuana is a healthy alternative to opioids. Congresswoman Brownley was concerned with VA's process for evaluating the efficacy of alternative therapies. Dr. Meyer stated that in accordance with the Comprehensive Addiction and Recovery Act (CARA), VA is in the process of expanding research, education and delivery of complementary medicine across all VISNs. Congressman Bergmann asked about the difference between the rates that opioids are prescribed at the VA compared to private providers. Dr. Meyer stated the number of Veterans prescribed opioids has decreased from 17.2% to 11.1 % (a 33% decrease) within VA, while the US average for adults is roughly 20%. Dr. Meyer also noted that Veterans who use Choice are prescribed opioids at a higher rate than if they were to stay in the VA system. In closing, Chairman Roe expressed his satisfaction with the roundtable.

July 18, 2017. The Acting USB and SME held a teleconference with Rep. Brownley to discuss the topic of overpayments as related to the GI Bill.

11:45 A.M.; Teleconference.

POC: (b)(6)

Summary: Summary will be provided tomorrow.

July 18, 2017. CLS participated in a CRS District Caseworker seminar and provide a basic casework briefing.

1:30 P.M.; Madison Building

POC: (b)(6)

Summary: Due to the timing of event a summary will be provided tomorrow.

July 18, 2017. (Postponed – June 28, 2017 and July 7, 2017). Cynthia Heaton, Chief, Health Administration Service, Deputy Director of Claims Adjudication and Reimbursement; held a follow

FOR INTERNAL USE ONLY

up meeting with Rep. Mike Thompson's (D-CA-05) Staff and the Director for Admitting and Patient Financial Services (APFS) for Sonoma Hospital to discuss the resolution of aging accounts receivable.

4:00 P.M.; Teleconference

POC: (b)(6)

Summary: Due to the timing of event a summary will be provided tomorrow.

Look Ahead- Wednesday, July 19, 2017

July 19, 2017. Sallie Houser-Hanfelter, Director, Denver VAMC and Ralph Gigliotti, VISN 19 Network Director, will meet with the Denver, Colorado delegation to discuss activation of the Denver VA facility.

9:00 A.M.; Teleconference

POC: (b)(6)

July 19, 2017: Mr. Ed Litvin, Director, OCAMES, will discuss the status of the proposed Veterans home in Flagstaff, AZ.

10:00 A.M.; Teleconference

POC: (b)(6)

July 19, 2017. SVAC will convene a hearing to consider the pending nominations of Tom Bowman to be Deputy Secretary of the Department of Veterans Affairs, Jim Byrne to be General Counsel of the Department of Veterans Affairs, Brooks Tucker to be Assistant Secretary of Congressional and Legislative Affairs of the Department of Veterans Affairs, and possibly others to be named later.

Witnesses: Tom Bowman, Jim Byrne, Brooks Tucker, and possibly others to be named later

2:30 P.M.; 418 Russell

POC: (b)(6)

July 19-20, 2017. Ms. Jennifer Gutowski, Director of VA Pacific Islands Health Care System, will meet with members of congress within her catchment area. She will also have a brief discussion with HVAC staff. The meetings will be introductory in nature, and she will share some of her insights resulting in the listening sessions she has held since her new appointment as Director.

10:00 A.M. - 2:00 P.M.; Capitol Hill

POCs: (b)(6)

July 19, 2017. Jennifer Gutowski, Director of VA Pacific Islands Health Care System, will meet with Delegate Radewagen to discuss VA care in American Samoa.

12:00 P.M.; 1339 Longworth

POC: (b)(6)

July 19, 2017. Clifford A. Smith, Deputy Director of Office of Mental Health and Suicide Prevention, will brief Democratic District Directors on implementation of VA's new OTH policy so local congressional offices can better assist constituents with casework.

1:00 P.M.; Teleconference

POC: (b)(6)

FOR INTERNAL USE ONLY

July 19, 2017. Jennifer Gutowski, Director of VA Pacific Islands Health Care System, will meet with Senator Hirono to discuss VA care in Hawaii.

2:00 P.M.; 330 Hart

POC: (b)(6)

July 19, 2017. (Postponed - May 19, 2017 and June 29, 2017). Jeff London, Director, VA Home Loan Guaranty Service, and Gerald Kifer, Supervisory Appraiser, VA Home Loan Guaranty Service, will brief HVAC Rep. Jim Banks (R-IN-03) on the general regulatory process and specific regulations affecting the VA Home Loan Program.

2:30 P.M.; 509 Cannon

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

July 25, 2017. HVAC Subcommittee on Disability Assistance and Memorial Affairs will hold a hearing on VBA's processing of claims for benefits based on Post-Traumatic Stress Disorder.

10:30 A.M.; 334 Cannon

Witness: TBD

POC: (b)(6)

July 25, 2017. The Committee on Veterans' Affairs Subcommittee on Health will host a roundtable discussion on telehealth in the VA healthcare system. During this roundtable, the Subcommittee will examine the use and effectiveness of telehealth techniques across the VA healthcare system as well as VA's response to challenges such as a lack of reimbursement structure for telehealth appointments and ambiguity surrounding VA providers' ability to practice telehealth.

2:00 P.M.; 334 Cannon

POC: (b)(6)

August 10, 2017. Field Hearing on Access to Care and Care in the Community both in rural areas. The hearing will be held in Duluth, MN, with the full committee. This hearing was at the request of the minority. It is a possibility Chairman Roe will not be in attendance, so another member of the majority will serve as the Chairman. They are requesting Dr. Yehia, someone from the Office of Rural Health, and a local witness (MCD).

Time and Location TBD

POC: (b)(6)

TBD. The HVAC EO Subcommittee will hold a legislative hearing on the agenda set out below.

Agenda

H.R. 43 - To authorize the use of Post-9/11 Educational Assistance to pursue independent study programs.

H.R. 245 - Veterans' Education Equity Act.

H.R. 1104 - Veterans To Enhance Studies Through Accessibility Act.

H.R. 1112 - Shauna Hill Post-9/11 Education Benefits Transferability Act.

H.R. 1216 - Protecting Veterans from School Closures Act of 2017.

H.R. 1331 - Veterans Success on Campus Act of 2017.

H.R. 1384 - Reserve Component Benefits Parity Act.

FOR INTERNAL USE ONLY

H.R. 1793 - Veteran Education Priority Enrollment Act of 2017.

H.R. 1956 - To increase the amounts of educational assistance payable under Survivors' and Dependents' Educational Assistance Program of the Department of Veterans Affairs.

H.R. 1989 - Veteran Employment Through Technology Education Courses Act.

H.R. 1994 - Vocational Education and Training Enhancement for Reintegration Assistance Now Act.

H.R. 2099 - GI Bill Fairness Act of 2017 Act.

H.R. 2100 - Work Study for Student Veterans Act.

H.R. 2103 - To include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program.

H.R. 2108 - GI Bill STEM Extension Act of 2017.

H.R. 2257 - To consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of the Department of Veterans Affairs.

Draft Bill - GI Bill Processing Improvement Act.

Draft Bill To provide for an election requirement and reduction in basic pay for members of the Armed Forces entitled to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program.

Witness: Curtis Coy, Deputy Under Secretary for Economic Opportunity.

10:00 A.M.; 334 Cannon

POC: (b)(6)

Member Engagement Requests for Senior Leaders

Sen/Rep	Last Name	First Name	State	Type of Engagement	Received	Date Scheduled	Topic
Sen	Tester	Jon	MT	Travel		8/24/2017	SecVA State Visit Request
Sen	Daines	Steve	MT	Travel		8/24/2017	Ft Harrison, MT
Rep	Bishop	Sanford	GA	Speech		9/22/2017	VA health care system for 2040, specifically for women and minorities
Sen	Rubio	Marco	FL	Meeting	5/4/2017		Accountability Legislation
Sen	Sullivan	Dan	AK	Travel	2/1/2017		SecVA State Visit Request
Sen	Manchin	Joe	WV	Travel	2/1/2017		SecVA State Visit Request
Rep	Esty	Elizabeth	CT	Travel	3/15/2017		Newington & Farmington, CT
Rep	Kuster	Ann McClane	NH	Travel	3/15/2017		Nashua, NH Homelessness/Suicide White River Junction - Opioid
Rep	Bacon	Don	NE	Meeting	3/23/2017		Omaha Ambulatory Care Center
Rep	Moulton	Seth	MA	Meeting	5/10/2017		Priorities
Rep	Arrington	Jodey	TX	Meeting	4/5/2017		VA Priorities – Proactive
Rep	Lieu	Ted	CA	Travel	5/30/2017		West LA
Rep	Gonzales-Colon	Jennifer	PR	Meeting	6/7/2017		Puerto Rico Concerns
Rep	Norcross	Donald	NJ	Meeting	6/8/2017		Constituent

FOR INTERNAL USE ONLY

Sen	Tillis/Tester		NC/MT	Meeting	6/20/2017		Choice
Rep	Rooney	Francis	FL	Travel	6/23/2017		
Rep	Davis/Bost	Rodney/Mike	IL	Travel	6/30/2017		Forum

From: (b)(6) </o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Thursday, July 13, 2017
Date: Wed Jul 12 2017 15:36:54 CDT
Attachments: image001
image002.png
Stand up -July 13.docx

All,

Attached is the Morning Report for Thursday, July 13, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Thursday, July 13, 2017

Hot Issues

***** The House will begin floor deliberations for the H.R. 2810, the National Defense Authorization Act for Fiscal Year 2018. Items of interest for VA include the annual transfer of funds to support the Joint DoD-VA Medical Facility Demonstration project. Other provisions of interest include: 1) a requirement for notification of certain Servicemembers that they petition VBA for certain benefits, despite the characterizations of their service; 2) allow more liberal consideration of medical evidence regarding PTSD or TBI who requests a review of their dismissal or discharge. There are numerous amendments expected to the bill – OCLA will continue to review them for items of relevance to VA.

Emerging

***** None

Congressional Letters and Meeting Requests Received

***** None

Wednesday, July 12, 2017 Events

***** July 11, 2017. The Senate Veterans' Affairs Committee held a hearing on the following bills:

- *S. 115 - The Veterans Transplant Coverage Act.
- *S. 426 - The Physician Assistant Employment and Education Act of 2017.
- *S. 683 - Keeping Our Commitment to Disabled Veterans Act of 2017.
- *S. 833 – Service members and Veterans Empowerment and Support Act.
- *S. 946 - Veterans Treatment Court Improvement Act.
- *S. 1153 - A bill to prohibit or suspend certain health care providers from providing non-Department of Veterans Affairs health care services to Veterans.
- *S. 1261 - Veterans Treatment Court Improvement Act.
- *S. 1266 - Enhancing Veteran Care Act.
- *S. 1279 - The Veterans Health Administration Reform Act.
- *S. 1325 - Better Workforce for Veterans Act.
- *S. ____ - Discussion Draft, The Veterans Choice Act of 2017.

***** S. ____ - Discussion Draft, Improving Veterans Access to Community Care Act of 2017.

***** S. ____ - The Department of Veterans Affairs Quality Employment Act of 2017.

1:00 P.M.; 418 Russell

POC: (b)(6)

Summary: The hearing this afternoon was cordial and highly attended by both Members and various interested groups. The first panel consisted of Senators Baldwin, Inhofe, Flake and Strange. Chairman Isakson and the Ranking Member Tester discussed their bills on the agenda focusing on the bipartisanship of the Committee and the importance of moving through Congress not only a better Choice program but a funded Choice program.

VA was the second panel which was led by Dr. Baligh Yehia and accompanied by Dr. Thomas Lynch, Carin Otero, and Brad Flohr. Dr. Yehia's statements were well received by all Members with additional appreciation on those bills VA supported. The Chairman focused his questions on the Department's key point of needing flexibility in funding and time needed to implement Choice. The Chairman asked how many community care programs does the Department have? Dr. Yehia made a point of stating what VA needs is one program and one account to fund it. Senator Sanders limited his question to a statement that he does not want and will not support privatization of the VA. Senator Boozman asked about the broader state of nursing care and the shortages VA faces. Dr. Lynch stated that VA is always working to improve and retain more nurses and that we share these same issues and complications with the private health care sector. Senator Boozman also noted that he wanted to work with the VA on issues the Department has with the Veterans Treatment Court Improvement Act. Senator Hirono focused the majority of her questions on her bill Keeping Our Commitment to Disabled Veterans which both VA and the VSO's supported. Additionally she wanted to note that in future Choice she wanted to make sure that current key partners were not harmed, but wanted flexibility in the program to partner with new and diversified providers. Senator Rounds focused his questions and statement on Choice eligibility and believes that broad eligibility and full discretion to the Veteran was necessary. Senator Rounds made it a point that he does not believe it is right that the Veterans has to get permission from the VA before they can be seen by an outside provider. Senator Tillis asked Dr. Lynch if the VA's biggest issue was the pay-for in the Veterans Treatment Court Improvement Act, which Dr. Lynch noted is the key issue as the bill requires the VA to take away funds from other programs to pay for something that we are already accomplishing without the legislation. Senator Tillis also wanted to give reassurances that he does not believe in privatizing the VA and that our brick and mortar operations are essential to Veteran care. He however does believe a balance is needed and wants to work with the Department to get there. Ranking Member Tester focused his questions on Choice 2.0 and asked Dr. Yehia if the VA should be responsible for damages to a Veteran when the VA sends them out in the community for care. Dr. Yehia and Brad Flohr responded by advising how the current process works and briefly noted there could be multiple problems with this concept if the VA has to pay. Senator Tester also brought up the costs for VA vs. Community Care. Dr. Yehia stated that he did not have figures for comparison of specific procedure costs between VA and the private sector, but did provide various costs that have been made public in the past related to what could occur if full enrollment were to be allowed. The third panel consisted of Veteran Service Organization (VSO) representatives from American Legion, Amvets, Disabled American Veterans (DAV) and Paralyzed Veterans of America. Though the VSO's written testimony focused on the entire agenda their oral statement primarily focused on Choice. The VSO's showed appreciation for the Member's trying to achieve a better VA, but had many concerns with the Choice bills on the agenda. Chairman Isakson appreciated that several of the VSO's pointed out how essential coordinate care was, which was a key point Dr. Yehia had made through his statements. He also asked the Legion if they polled their Veterans for VA healthcare satisfaction and if they did, did the VA take into account the result of the polling. The Legion advised that they poll often and at various times and locations. They made it a point that VA does listen and they appreciate the responsiveness, availability and transparency that the VA has with the VSO's which has gotten better over the last few years. Ranking Member Tester took an opportunity to gage VSO thoughts/position on his new draft bill that was dropped today regarding funding Choice. Legion and Amvets were supportive, DAV was looking

at it more now, and PVA wants to know where exactly the money would go. Senator Tillis focused on funding Choice as well, with Legion making it clear that they want Choice funded by all means necessary but not through the cannibalization of other programs. Senator Tillis went on to make it clear that there needed to be sustainable, predictable funding. Senator Blumenthal asked who should be responsible for the decision making process under Choice. DAV noted that the VA should be more empowered to make the right decisions between the Veteran and their doctor. Senator Blumenthal also asked if they are satisfied with the OIG investigation in Phoenix. The Legion noted that it is still a work in progress.

***** July 11, 2017. Alan Swygert, Chief of VHA Vendor Relations met with Rep. Steve Knight's (CA-25) and Rep. Kevin McCarthy (CA-23) staffs to further discuss the viability of funding a pilot program in West LA VA Medical Center.

2:30 P.M.: 1023 Longworth

POC: (b)(6)

Summary: The staff had questions specific to the CVS pilot currently operating in the Palo Alto VAMC. Rep. Knight and Rep. McCarthy have a shared interest in establishing a similar pilot in Bakersfield Clinic or within Kern County through a local vendor, TreatMedNGo. Both Members recently met with CVS who mentioned the success of the pilot. While both Members are impressed by the increase in access to care afforded to the Veteran population in California, they notice that the amount per claim grossly exceeds the amount paid per Veteran in the Phoenix pilot pay model. They request a breakdown showing the difference between the Palo Alto pilot and the Phoenix pilot in terms of cost per Veteran. Mr. Swygert explained that operationally, they're identical, the difference is that Palo Alto pays directly to the vendor while Phoenix pays using traditional community care funds.

***** July 12, 2017. Subject matter experts Roberto Santos, Clay Curtis, and Ruth Beltran-West from the VA Office of Information Technology, Juan Quinones and Chuck Ross from the Office of Acquisition Operations Technology Acquisition Center, Dr. Michael Davies of VHA, along with Mark Byers, Robert Missroon, Rodney Neal, and Brooks Banton of DSS, Inc., will provide an update on VA's implementation of the Faster Care for Veterans (VA118-17-R-1848) Pilot to Rep. Moulton (D-MA-06), Bill Mallison and Grace Rodden from HVAC, and Hilary Ranieri from the office of Rep. McMorris Rogers (R-WA-05).

10:00 A.M.; Republican Conference Office B-245

POC: (b)(6)

Summary: A summary will be provided on tomorrow's report.

***** July 12, 2017. HVAC full committee convened a hearing to discuss the Department of Veterans Affairs' (VA's) capital asset program. The Committee assessed the findings and recommendations of GAO, the Independent Assessment, and the Commission on Care with respect to VA's capital asset planning and approval process as well as the recent announcement by Secretary Shulkin of his intention to dispose of all vacant VA buildings in the next 2 years. The Committee also considered other actions that may be needed to address VA's vast and aging capital asset portfolio.

10:00 A.M.; 334 Cannon

POC: (b)(6)

Summary: Chairman Roe opened the hearing by calling for a top-to-bottom review of all VHA capital assets, however, the hearing mainly focused on the Secretary Shulkin's plan to dispose of vacant and underutilized properties. Committee members expressed support for closing properties and reallocating savings toward direct patient care. They also expressed support for greater use of public private partnerships and expanded EUL authority. Some members expressed concern regarding the 4% cut in the FY18 construction budget request and the ongoing delays with the authorization of VA's capital leases. Other topics discussed included the potential sale of Pershing Hall, the effectiveness of SCIP and VAIP, and increased engagement with VSO on managing capital assets.

***** July 12, 2017. The House Transportation & Infrastructure Subcommittee on Economic Development, Public Buildings, and Emergency Management held a hearing to discuss property disposals and implementation of the Federal Assets Sale and Transfer Act (FASTA).

Witnesses: Brett Simms, Director Capital Asset Management Service, OAEM.

10:00 A.M.; 2167 Rayburn

POC: (b)(6)

Summary: The hearing focused on GSA's ability under current regulations to decrease the amount of time to dispose of federal property. Mr. Simms provided information on VA's property disposal process in performing due diligence to complete the required studies and analysis regarding excess properties. This includes supporting housing for homeless Veterans and the private-sector demand for the property. Mr. Simms stated that VA will work with the local community and interested developers/operators and service providers to bring those services to the Veterans in need. Mr. Simms also provided information on the challenges utilizing EUL agreement to provide housing for homeless Veterans—VA's limited authority to fund EUL projects. It was recommended, VA and GSA should continue to engage public and private companies' interests in federal vacant properties.

***** July 12, 2017. Ed Litvin, Director, Office of Capital Asset Management Engineering and Support; briefed HVAC majority staff, staff for Members of the Tennessee Congressional Delegation and local officials from Bradley County, Tennessee on the State Veterans Homes (SVH) funding/prioritizing process.

12:00 P.M.; Teleconference

POC: (b)(6)

Summary: HVAC Chairman Roe and Members of the Tennessee Delegation are monitoring a SVH new construction project in Cleveland, Tennessee. The Bradley County spokesman was well versed in the SVH Construction Grant program operations and the Federal regulations that govern its operation. The project started in 2003, local people watch the priority list closely; he expressed frustration that it has not been funded; said the simple solution would be more funding for SVH construction. He wanted to understand the finer points of the dynamics that affect the annual priority list; how other projects rocket to the top of the list; and also asked questions about two Virginia projects that were no longer on the list; VA advised that Virginia has decided to build them without Federal funds. County Commissioner Mark Hall said they needed to be more assertive, proactive and wanted to know what they could do to expedite their project. They thanked VA and congressional staff for listening to their concerns.

***** July 12, 2017. HVAC Oversight and Investigations Subcommittee is scheduled to markup the following list of pending legislation which were previously the subject of a legislative hearing on June 29, 2017.

1:00 PM 334 Cannon

POC: (b)(6)

Markup Agenda:

H.R. 2006, VA Procurement Efficiency and Transparency Act

- o This bill would require VA to calculate and record cost avoidance achieved through the procurement process.
- o VA does not support

H.R. 2749, Protecting Business Opportunities for Veterans Act of 2017

- o The bill would clarify the performance expectations for Service-Disabled Veteran-Owned Small Businesses and Veteran-Owned Small Businesses receiving contracts under the Veterans First Contracting Program authorities
- o VA has concerns with the bill, as drafted.

H.R. 2781, Ensuring Veteran Enterprise Participation in Strategic Sourcing Act

- o This bill would require the Secretary to make certain certifications related to the efficacy of Office of Procurement Policy, the General Services Administration, and various Category manager efforts to streamline Federal buying practices and improve Federal business outcomes
- o VA does not support

H.R. 3169, VA Acquisition Workforce Improvement and Streamlining Act

- o This bill requires VA to develop and implement a training and certification program for acquisition personnel
- o VA does not support

Summary: The markup meeting lasted approximately 15 minutes, gavel-to-gavel. Chairman Bergman noted that the Committee received technical assistance on H.R. 2749 from the VA and is still interested in receiving technical assistance on the remaining bills on the agenda; H.R. 2006, H.R. 2781, and H.R. 3169. According to the Chairman, CBO has stated that of the four bills, only H.R. 3169 will contain significant costs, while the costs for the remaining bills will be insignificant. Ranking Member Kuster expressed her support for H.R. 2749 and H.R. 3169. There was no indication during the markup on when the bills would be considered by the Full Committee. Rep. Dunn, also spoke briefly on his support for H.R. 2781.

***** July 12, 2017. HVAC Economic Opportunity Subcommittee is scheduled to markup the following list of pending legislation which were previously the subject of a legislative hearing on June 29, 2017.

2:00 PM 334 Cannon Office Building

POC: (b)(6)

Markup Agenda:

1. H.R. 282, Military Residency Choice Act

- o Would amend the Servicemembers Civil Relief Act regarding various tax and residency matters
- o VA deferred to Department of Justice, Internal Revenue Service, and the Department of Defense

2. H.R. 1690, Department of Veterans Affairs Bonus Transparency Act

- o Would require VA to submit an annual report to Congress regarding performance awards and bonuses awarded to high-level and executive employees at VA in the most recent fiscal year
- o VA supports the requirement to submit annual report but does not support providing report within 30 days of the end of the fiscal year.

3. H.R. 2772, VA Senior Executive Accountability Act or the "SEA Act"

- o Would prohibit the reassignment of VA senior executive employees to similar position within the Department without written approval by the Secretary.
- o VA supports with technical revisions.

Summary: H.R. 1690, was agreed to, as amended, and reported favorably to the Full Committee. The amendment was offered by Rep. O'Rourke and changed the reporting requirement from "not later than 30 days" to "not later than 120 days". H.R. 282 and H.R. 2772 was voted on en bloc and reported favorably to the Full Committee. The Chairman gave no

indication on when the bills would be scheduled for a Full Committee markup.

***** July 12, 2017. The Senate Appropriations Military Construction/VA Subcommittee will hold a business meeting to mark up its draft FY2018 Military Construction-VA appropriations measure.

2:30 P.M.; 124 Dirksen Senate Office Building

POC: (b)(6) Office of Management

Summary: Due to the timing of the event, a summary will be provided on tomorrow's report.

***** July 12, 2017. Jonathan Hughes, Chief, Compensation Service, and Brad Flohr, Senior

Advisor for Compensation Service will meet with Rep. Markwayne Mullin

(OK-02) to discuss agent orange exposure claims management and adjudication.

4:30 P.M.; 1113 Longworth

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided on tomorrow's report.

***** July 12, 2017. VISN 19 leadership will provide a "State of the VISN 19 Network and Medical Centers" briefing to Members of Congress within the VISN catchment area. Meetings for Wednesday include:

- o Rep. Ken Buck (R-CO-04)
- o Rep. Liz Cheney (WY-At Large)
- o Sen. John Barrasso (R-WY)
- o Sen. James Inhofe (R-OK)
- o Sen. James Lankford (R-OK)

Meetings will be held at varying times and locations

POC: (b)(6)

Summary: A summary will be provided on tomorrow's report.

Look Ahead- Thursday, July 13, 2017

***** July 13, 2017. The National Academic Affiliations Council (NAAC), a chartered Federal advisory committee, will meet on a number of issues including: VA Diversity and Inclusion Summit – Rep. Sanford Bishop, Jr., (GA-02) has been invited to make remarks; and VACAA Graduate Medical Education Update – Rep. Mark Takano, (CA-41) has been invited to make remarks.

8:00 A.M. – 2:00 P.M.; H-201 A/B, U.S. Capitol Visitors Center

POCs: (b)(6)

***** July 13, 2017. The full Senate Appropriations Committee will hold a business meeting to mark up its draft FY2018 Military Construction-VA appropriations measure.

10:00 A.M.; 106 Dirksen Senate Office Building

POC: (b)(6) Office of Management

***** July 13, 2017. HVAC Subcommittees on Oversight and Investigations and Disability Assistance and Memorial Affairs will hold a hearing on "Examining VA's Processing of Gulf War Illness Claims."

10:00 A.M.; 334 Cannon

Witness: Brad Flohr, Senior Advisor for Compensation Service, VBA, and Patrick Joyce, Chief, Occupational Health Clinics, Washington VAMC, VHA.

POC: (b)(6)

***** July 13, 2017. Mr. Michael Amaral, Director, El Paso VA Health Care System, will have a brief introductory meeting with Rep. Pearce. He will also discuss staff concerns he has learned of since his appointment as facility Director.

1:00 P.M.; 2432 Rayburn

POC: (b)(6)

***** July 13, 2017. Dr. Wendy Tenhula, Deputy Chief Consultant for Specialty Mental Health and Dr. Joseph Thornton, Mental Health, North Florida/South Georgia VHS, will brief staff from the offices of Congressmen Al Lawson (FL-05) and John Rutherford (FL-04) on VA mental health initiatives.

2:00 P.M.; 421 Cannon

POC: (b)(6)

***** July 13, 2017. HVAC Subcommittee on Health will meet in open session to conduct a hearing on VA Clinical Productivity and Efficiency.

2:00 P.M.; 334 Cannon

POC: (b)(6)

***** July 13, 2017. Dr. Peter Alemenoff, Deputy Executive Director, Clinical Integration, Office of Community Care will meet with SVAC minority staff for a discussion on the SAIL data for Montana.

3:00 P.M.; 825A Hart

POC: (b)(6)

***** July 13, 2017. VISN 19 leadership will provide a "State of the VISN 19 Network and Medical Centers" briefing to members within the VISN catchment area. Meetings for Thursday include:

***** Rep. Markwayne Mullin (R-OK-02)

***** Sen. Mike Lee (R-UT)

***** Sen. Michael Bennet (D-CO)

***** Sen. Orrin Hatch (R-UT)

***** Rep. Chris Stewart (R-UT-02)

Meetings will be held at varying times and locations

POC: (b)(6)

Government Accountability Office (GAO) Activity:

Entrance Conferences

July 13, 2017. In response to a request from the Chairman of House Veterans Affairs Committee, GAO is beginning its review on Healthcare Facilities Operations and Maintenance (GAO Code 102114).

GAO's Objectives are to answer the following questions:

***** VA's process for planning for operations and maintenance needs at VA medical facilities, including budgeting and cost estimations;

***** The effectiveness of VA's oversight of VA medical facilities operations and maintenance needs, at the national and local levels;

***** The challenges, if any, VA faces in operation and maintaining medial facilities, and how those challenges are addressed.

11:00 A.M.; VACO, Room 630

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

***** (Tentative) July 17, 2017. The HVAC full committee is tentatively scheduled to hold a legislative hearing on one draft bill related to GI Bill benefits

Time: TBD Room: TBD

POC: (b)(6)

***** July 18, 2017. The House Committee on Veterans Affairs Chairman, Rep. Phil Roe, will hold a roundtable discussion on the opioid crisis. The discussion will center on how the opioid crisis is affecting our Veteran population and what are some potential solutions to curbing opioid abuse.

10:00 A.M.; 334 Cannon

POC: (b)(6)

***** July 18, 2017. HVAC DAMA intends to hold a Roundtable on Disability Examinations.

2:00 P.M.; 334 Cannon

Witnesses: Beth Murphy, Director, Compensation Service, VBA; Mary Glenn, Deputy Director for Contract Exams, Compensation Service, VBA; Patricia Murray, Chief Officer, Office of Disability and Medical Assessment, VHA

POC: (b)(6)

***** July 19, 2017. SVAC will convene a hearing to consider the pending nominations of Tom Bowman to be Deputy Secretary of the Department of Veterans Affairs, Jim Byrne to be General Counsel of the Department of Veterans Affairs, Brooks Tucker to be Assistant Secretary of Congressional and Legislative Affairs of the Department of Veterans Affairs, and possibly others to be named later.

Witnesses: Tom Bowman, Jim Byrne, Brooks Tucker, and possibly others to be named later

2:30 P.M.; 418 Russell

POC: (b)(6)

***** July 25, 2017. HVAC Subcommittee on Disability Assistance and Memorial Affairs will hold a hearing on VBA's processing of claims for benefits based on Post-Traumatic Stress Disorder.

10:30 A.M.; 334 Cannon

Witness: TBD

POC: (b)(6)

***** TBD. Field Hearing on Access to Care and Care in the Community both in rural areas. The hearing will be held in Duluth, MN, with the full committee. This hearing was at the request of the

minority. It is a possibility Chairman Roe will not be in attendance, so another member of the majority will serve as the Chairman. They are requesting Dr. Yehia, someone from the Office of Rural Health, and a local witness (MCD).

Time and Location TBD

POC: (b)(6)

***** TBD. The HVAC EO Subcommittee will hold a legislative hearing on the agenda set out below.

Agenda

***** H.R. 43 - To authorize the use of Post-9/11 Educational Assistance to pursue independent study programs.

***** H.R. 245 - Veterans' Education Equity Act.

***** H.R. 1104 - Veterans To Enhance Studies Through Accessibility Act.

***** H.R. 1112 - Shauna Hill Post-9/11 Education Benefits Transferability Act.

***** H.R. 1216 - Protecting Veterans from School Closures Act of 2017.

***** H.R. 1331 - Veterans Success on Campus Act of 2017.

***** H.R. 1384 - Reserve Component Benefits Parity Act.

***** H.R. 1793 - Veteran Education Priority Enrollment Act of 2017.

***** H.R. 1956 - To increase the amounts of educational assistance payable under Survivors' and Dependents' Educational Assistance Program of the Department of Veterans Affairs.

***** H.R. 1989 - Veteran Employment Through Technology Education Courses Act.

***** H.R. 1994 - Vocational Education and Training Enhancement for Reintegration Assistance Now Act.

***** H.R. 2099 - GI Bill Fairness Act of 2017 Act.

***** H.R. 2100 - Work Study for Student Veterans Act.

***** H.R. 2103 - To include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program.

***** H.R. 2108 - GI Bill STEM Extension Act of 2017.

***** H.R. 2257 - To consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of the Department of Veterans Affairs.

***** Draft Bill - GI Bill Processing Improvement Act.

***** Draft Bill To provide for an election requirement and reduction in basic pay for members of the

Armed Forces entitled to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program.

Witness: Curtis Coy, Deputy Under Secretary for Economic Opportunity.

10:00 A.M.; 334 Cannon

POC: (b)(6)

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Sen

Tester

Jon

MT

Travel

8/24/2017

SecVA State Visit Request

Sen

Daines

Steve

MT

Travel

8/24/2017

Ft Harrison, MT

Rep

Bishop

Sanford

GA

Speech

9/22/2017

VA health care system for 2040, specifically for women and minorities

Sen

Rubio

Marco

FL

Meeting

5/4/2017

Accountability Legislation

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA State Visit Request

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide White River Junction - Opioid

Rep

Bacon

Don

NE

Meeting

3/23/2017

Omaha Ambulatory Care Center

Rep

Moulton

Seth

MA

Meeting

5/10/2017

Priorities

Rep

Arrington

Jodey

TX

Meeting

4/5/2017

VA Priorities – Proactive

Rep

Lieu

Ted

CA

Travel

5/30/2017

West LA

Rep

Gonzales-Colon

Jennifer

PR

Meeting

6/7/2017

Puerto Rico Concerns

Rep

Norcross

Donald

NJ

Meeting

6/8/2017

Constituent

Sen

Tillis/Tester

NC/MT

Meeting

6/20/2017

Choice

Rep

Rooney

Francis

FL

Travel

6/23/2017

Rep

Davis/Bost

Rodney/ Mike

IL

Travel

6/30/2017

Forum

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)>
Filename: image001 <extracted>
Last Modified: Wed Jul 12 15:36:54 CDT 2017

image001<extracted> for Printed Item: 71 (. Attachment 1 of 3)
This document contains proprietary information and should not be released, in whole or in part, to non -VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or **competing** Member offices that should not be shared with other congressional entities

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: image002.png
Last Modified: Wed Jul 12 15:36:54 CDT 2017

Page 002 of 007 Printed Item 71 (Attachments 2 of 3) This information should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or competing Member offices that should not be shared with other entities. Page 916 of 974

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: Stand up -July 13.docx
Last Modified: Wed Jul 12 15:36:54 CDT 2017

FOR INTERNAL USE ONLY

Secretary's Morning Report
Prepared by the Office of Congressional & Legislative Affairs
Thursday, July 13, 2017

This document contains proprietary information and should not be released, in whole or in part, to non-VA personnel. Proprietary information often involves issues of policy, oversight, or political sensitivity among legislative committees or **competing** Member offices that should not be shared with other congressional entities

Hot Issues

The House will begin floor deliberations for the H.R. 2810, the National Defense Authorization Act for Fiscal Year 2018. Items of interest for VA include the annual transfer of funds to support the Joint DoD-VA Medical Facility Demonstration project. Other provisions of interest include: 1) a requirement for notification of certain Servicemembers that they petition VBA for certain benefits, despite the characterizations of their service; 2) allow more liberal consideration of medical evidence regarding PTSD or TBI who requests a review of their dismissal or discharge. There are numerous amendments expected to the bill – OCLA will continue to review them for items of relevance to VA.

Emerging

None

Congressional Letters and Meeting Requests Received

None

Wednesday, July 12, 2017 Events

July 11, 2017. The Senate Veterans' Affairs Committee held a hearing on the following bills:

- S. 115** - The Veterans Transplant Coverage Act.
- S. 426** - The Physician Assistant Employment and Education Act of 2017.
- S. 683** - Keeping Our Commitment to Disabled Veterans Act of 2017.
- S. 833** – Service members and Veterans Empowerment and Support Act.
- S. 946** - Veterans Treatment Court Improvement Act.
- S. 1153** - A bill to prohibit or suspend certain health care providers from providing non-Department of Veterans Affairs health care services to Veterans.
- S. 1261** - Veterans Treatment Court Improvement Act.
- S. 1266** - Enhancing Veteran Care Act.
- S. 1279** - The Veterans Health Administration Reform Act.
- S. 1325** - Better Workforce for Veterans Act.
- S. ____** - Discussion Draft, The Veterans Choice Act of 2017.
- S. ____** - Discussion Draft, Improving Veterans Access to Community Care Act of 2017.
- S. ____** - The Department of Veterans Affairs Quality Employment Act of 2017.

1:00 P.M.; 418 Russell

POC: (b)(6)

FOR INTERNAL USE ONLY

Summary: The hearing this afternoon was cordial and highly attended by both Members and various interested groups. The first panel consisted of Senators Baldwin, Inhofe, Flake and Strange. Chairman Isakson and the Ranking Member Tester discussed their bills on the agenda focusing on the bipartisanship of the Committee and the importance of moving through Congress not only a better Choice program but a funded Choice program. VA was the second panel which was led by Dr. Baligh Yehia and accompanied by Dr. Thomas Lynch, Carin Otero, and Brad Flohr. Dr. Yehia's statements were well received by all Members with additional appreciation on those bills VA supported. The Chairman focused his questions on the Department's key point of needing flexibility in funding and time needed to implement Choice. The Chairman asked how many community care programs does the Department have? Dr. Yehia made a point of stating what VA needs is one program and one account to fund it. Senator Sanders limited his question to a statement that he does not want and will not support privatization of the VA. Senator Boozman asked about the broader state of nursing care and the shortages VA faces. Dr. Lynch stated that VA is always working to improve and retain more nurses and that we share these same issues and complications with the private health care sector. Senator Boozman also noted that he wanted to work with the VA on issues the Department has with the Veterans Treatment Court Improvement Act. Senator Hirono focused the majority of her questions on her bill Keeping Our Commitment to Disabled Veterans which both VA and the VSO's supported. Additionally she wanted to note that in future Choice she wanted to make sure that current key partners were not harmed, but wanted flexibility in the program to partner with new and diversified providers. Senator Rounds focused his questions and statement on Choice eligibility and believes that broad eligibility and full discretion to the Veteran was necessary. Senator Rounds made it a point that he does not believe it is right that the Veterans has to get permission from the VA before they can be seen by an outside provider. Senator Tillis asked Dr. Lynch if the VA's biggest issue was the pay-for in the Veterans Treatment Court Improvement Act, which Dr. Lynch noted is the key issue as the bill requires the VA to take away funds from other programs to pay for something that we are already accomplishing without the legislation. Senator Tillis also wanted to give reassurances that he does not believe in privatizing the VA and that our brick and mortar operations are essential to Veteran care. He however does believe a balance is needed and wants to work with the Department to get there. Ranking Member Tester focused his questions on Choice 2.0 and asked Dr. Yehia if the VA should be responsible for damages to a Veteran when the VA sends them out in the community for care. Dr. Yehia and Brad Flohr responded by advising how the current process works and briefly noted there could be multiple problems with this concept if the VA has to pay. Senator Tester also brought up the costs for VA vs. Community Care. Dr. Yehia stated that he did not have figures for comparison of specific procedure costs between VA and the private sector, but did provide various costs that have been made public in the past related to what could occur if full enrollment were to be allowed. The third panel consisted of Veteran Service Organization (VSO) representatives from American Legion, Amvets, Disabled American Veterans (DAV) and Paralyzed Veterans of America. Though the VSO's written testimony focused on the entire agenda their oral statement primarily focused on Choice. The VSO's showed appreciation for the Member's trying to achieve a better VA, but had many concerns with the Choice bills on the agenda. Chairman Isakson appreciated that several of the VSO's pointed out how essential coordinate care was, which was a key point Dr. Yehia had made through his statements. He also asked the Legion if they polled their Veterans for VA healthcare satisfaction and if they did, did the VA take into account the result of the polling. The Legion advised that they poll often and at various times and locations. They made it a point that VA does listen and they appreciate the responsiveness, availability and transparency that the VA has with the VSO's

FOR INTERNAL USE ONLY

which has gotten better over the last few years. Ranking Member Tester took an opportunity to gage VSO thoughts/position on his new draft bill that was dropped today regarding funding Choice. Legion and Amvets we supportive, DAV was looking at it more now, and PVA wants to know where exactly the money would go. Senator Tillis focused on funding Choice as well, with Legion making it clear that they want Choice funded by all means necessary but not through the cannibalization of other programs. Senator Tillis went on to make it clear that there needed to be sustainable, predictable funding. Senator Blumenthal asked who should be responsible for the decision making process under Choice. DAV noted that the VA should be more empowered to make the right decisions between the Veteran and their doctor. Senator Blumenthal also asked if they are satisfied with the OIG investigation in Phoenix. The Legion noted that it is still a work in progress.

July 11, 2017. Alan Swygert, Chief of VHA Vendor Relations met with Rep. Steve Knight's (CA-25) and Rep. Kevin McCarthy (CA-23) staffs to further discuss the viability of funding a pilot program in West LA VA Medical Center.

2:30 P.M: 1023 Longworth

POC: (b)(6)

Summary: The staff had questions specific to the CVS pilot currently operating in the Palo Alto VAMC. Rep. Knight and Rep. McCarthy have a shared interest in establishing a similar pilot in Bakersfield Clinic or within Kern County through a local vendor, TreatMedNGo. Both Members recently met with CVS who mentioned the success of the pilot. While both Members are impressed by the increase in access to care afforded to the Veteran population in California, they notice that the amount per claim grossly exceeds the amount paid per Veteran in the Phoenix pilot pay model. They request a breakdown showing the difference between the Palo Alto pilot and the Phoenix pilot in terms of cost per Veteran. Mr. Swygert explained that operationally, they're identical, the difference is that Palo Alto pays directly to the vendor while Phoenix pays using traditional community care funds.

July 12, 2017. Subject matter experts Roberto Santos, Clay Curtis, and Ruth Beltran-West from the VA Office of Information Technology, Juan Quinones and Chuck Ross from the Office of Acquisition Operations Technology Acquisition Center, Dr. Michael Davies of VHA, along with Mark Byers, Robert Missroon, Rodney Neal, and Brooks Banton of DSS, Inc., will provide an update on VA's implementation of the Faster Care for Veterans (VA118-17-R-1848) Pilot to Rep. Moulton (D-MA-06), Bill Mallison and Grace Rodden from HVAC, and Hilary Ranieri from the office of Rep. McMorris Rogers (R-WA-05).

10:00 A.M.: Republican Conference Office B-245

POC: (b)(6)

Summary: A summary will be provided on tomorrow's report.

July 12, 2017. HVAC full committee convened a hearing to discuss the Department of Veterans Affairs' (VA's) capital asset program. The Committee assessed the findings and recommendations of GAO, the Independent Assessment, and the Commission on Care with respect to VA's capital asset planning and approval process as well as the recent announcement by Secretary Shulkin of his intention to dispose of all vacant VA buildings in the next 2 years. The Committee also considered other actions that may be needed to address VA's vast and aging capital asset portfolio.

10:00 A.M.; 334 Cannon

POC: (b)(6)

FOR INTERNAL USE ONLY

Summary: Chairman Roe opened the hearing by calling for a top-to-bottom review of all VHA capital assets, however, the hearing mainly focused on the Secretary Shulkin's plan to dispose of vacant and underutilized properties. Committee members expressed support for closing properties and reallocating savings toward direct patient care. They also expressed support for greater use of public private partnerships and expanded EUL authority. Some members expressed concern regarding the 4% cut in the FY18 construction budget request and the ongoing delays with the authorization of VA's capital leases. Other topics discussed included the potential sale of Pershing Hall, the effectiveness of SCIP and VAIP, and increased engagement with VSO on managing capital assets.

July 12, 2017. The House Transportation & Infrastructure Subcommittee on Economic Development, Public Buildings, and Emergency Management held a hearing to discuss property disposals and implementation of the Federal Assets Sale and Transfer Act (FASTA).

Witnesses: Brett Simms, Director Capital Asset Management Service, OAEM.

10:00 A.M.; 2167 Rayburn

POC: (b)(6)

Summary: The hearing focused on GSA's ability under current regulations to decrease the amount of time to dispose of federal property. Mr. Simms provided information on VA's property disposal process in performing due diligence to complete the required studies and analysis regarding excess properties. This includes supporting housing for homeless Veterans and the private-sector demand for the property. Mr. Simms stated that VA will work with the local community and interested developers/operators and service providers to bring those services to the Veterans in need. Mr. Simms also provided information on the challenges utilizing EUL agreement to provide housing for homeless Veterans—VA's limited authority to fund EUL projects. It was recommended, VA and GSA should continue to engage public and private companies' interests in federal vacant properties.

July 12, 2017. Ed Litvin, Director, Office of Capital Asset Management Engineering and Support; briefed HVAC majority staff, staff for Members of the Tennessee Congressional Delegation and local officials from Bradley County, Tennessee on the State Veterans Homes (SVH) funding/prioritizing process.

12:00 P.M.; Teleconference

POC: (b)(6)

Summary: HVAC Chairman Roe and Members of the Tennessee Delegation are monitoring a SVH new construction project in Cleveland, Tennessee. The Bradley County spokesman was well versed in the SVH Construction Grant program operations and the Federal regulations that govern its operation. The project started in 2003, local people watch the priority list closely; he expressed frustration that it has not been funded; said the simple solution would be more funding for SVH construction. He wanted to understand the finer points of the dynamics that affect the annual priority list; how other projects rocket to the top of the list; and also asked questions about two Virginia projects that were no longer on the list; VA advised that Virginia has decided to build them without Federal funds. County Commissioner Mark Hall said they needed to be more assertive, proactive and wanted to know what they could do to expedite their project. They thanked VA and congressional staff for listening to their concerns.

July 12, 2017. HVAC Oversight and Investigations Subcommittee is scheduled to markup the following list of pending legislation which were previously the subject of a legislative hearing on June 29, 2017.

1:00 PM 334 Cannon

FOR INTERNAL USE ONLY

POC: (b)(6)

Markup Agenda:**H.R. 2006, VA Procurement Efficiency and Transparency Act**

- This bill would require VA to calculate and record cost avoidance achieved through the procurement process.
- VA does not support

H.R. 2749, Protecting Business Opportunities for Veterans Act of 2017

- The bill would clarify the performance expectations for Service-Disabled Veteran-Owned Small Businesses and Veteran-Owned Small Businesses receiving contracts under the Veterans First Contracting Program authorities
- VA has concerns with the bill, as drafted.

H.R. 2781, Ensuring Veteran Enterprise Participation in Strategic Sourcing Act

- This bill would require the Secretary to make certain certifications related to the efficacy of Office of Procurement Policy, the General Services Administration, and various Category manager efforts to streamline Federal buying practices and improve Federal business outcomes
- VA does not support

H.R. 3169, VA Acquisition Workforce Improvement and Streamlining Act

- This bill requires VA to develop and implement a training and certification program for acquisition personnel
- VA does not support

Summary: The markup meeting lasted approximately 15 minutes, gavel-to-gavel. Chairman Bergman noted that the Committee received technical assistance on H.R. 2749 from the VA and is still interested in receiving technical assistance on the remaining bills on the agenda; H.R. 2006, H.R. 2781, and H.R. 3169. According to the Chairman, CBO has stated that of the four bills, only H.R. 3169 will contain significant costs, while the costs for the remaining bills will be insignificant. Ranking Member Kuster expressed her support for H.R. 2749 and H.R. 3169. There was no indication during the markup on when the bills would be considered by the Full Committee. Rep. Dunn, also spoke briefly on his support for H.R. 2781.

July 12, 2017. HVAC Economic Opportunity Subcommittee is scheduled to markup the following list of pending legislation which were previously the subject of a legislative hearing on June 29, 2017.

2:00 PM 334 Cannon Office Building

POC: (b)(6)

Markup Agenda:**1. H.R. 282, Military Residency Choice Act**

- Would amend the Servicemembers Civil Relief Act regarding various tax and residency matters
- VA deferred to Department of Justice, Internal Revenue Service, and the Department of Defense

2. H.R. 1690, Department of Veterans Affairs Bonus Transparency Act

FOR INTERNAL USE ONLY

- Would require VA to submit an annual report to Congress regarding performance awards and bonuses awarded to high-level and executive employees at VA in the most recent fiscal year
 - VA supports the requirement to submit annual report but does not support providing report within 30 days of the end of the fiscal year.
3. **H.R. 2772**, VA Senior Executive Accountability Act or the “SEA Act”
- Would prohibit the reassignment of VA senior executive employees to similar position within the Department without written approval by the Secretary.
 - VA supports with technical revisions.

Summary: H.R. 1690, was agreed to, as amended, and reported favorably to the Full Committee. The amendment was offered by Rep. O'Rourke and changed the reporting requirement from “not later than 30 days” to “not later than 120 days”. H.R. 282 and H.R. 2772 was voted on *en bloc* and reported favorably to the Full Committee. The Chairman gave no indication on when the bills would be scheduled for a Full Committee markup.

July 12, 2017. The Senate Appropriations Military Construction/VA Subcommittee will hold a business meeting to mark up its draft FY2018 Military Construction-VA appropriations measure. 2:30 P.M.; 124 Dirksen Senate Office Building

POC: (b)(6) Office of Management

Summary: Due to the timing of the event, a summary will be provided on tomorrow's report.

July 12, 2017. Jonathan Hughes, Chief, Compensation Service, and Brad Flohr, Senior Advisor for Compensation Service will meet with Rep. Markwayne Mullin (OK-02) to discuss agent orange exposure claims management and adjudication.

4:30 P.M.; 1113 Longworth

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided on tomorrow's report.

July 12, 2017. VISN 19 leadership will provide a “State of the VISN 19 Network and Medical Centers” briefing to Members of Congress within the VISN catchment area. Meetings for Wednesday include:

- Rep. Ken Buck (R-CO-04)
- Rep. Liz Cheney (WY-At Large)
- Sen. John Barrasso (R-WY)
- Sen. James Inhofe (R-OK)
- Sen. James Lankford (R-OK)

Meetings will be held at varying times and locations

POC: (b)(6)

Summary: A summary will be provided on tomorrow's report.

Look Ahead- Thursday, July 13, 2017
--

July 13, 2017. The National Academic Affiliations Council (NAAC), a chartered Federal advisory committee, will meet on a number of issues including: VA Diversity and Inclusion Summit – Rep. Sanford Bishop, Jr., (GA-02) has been invited to make remarks; and VACAA Graduate Medical Education Update – Rep. Mark Takano, (CA-41) has been invited to make remarks.

8:00 A.M. – 2:00 P.M.; H-201 A/B, U.S. Capitol Visitors Center

POCs: (b)(6)

FOR INTERNAL USE ONLY

July 13, 2017. The full Senate Appropriations Committee will hold a business meeting to mark up its draft FY2018 Military Construction-VA appropriations measure.

10:00 A.M.; 106 Dirksen Senate Office Building

POC: (b)(6) Office of Management

July 13, 2017. HVAC Subcommittees on Oversight and Investigations and Disability Assistance and Memorial Affairs will hold a hearing on "Examining VA's Processing of Gulf War Illness Claims."

10:00 A.M.; 334 Cannon

Witness: Brad Flohr, Senior Advisor for Compensation Service, VBA, and Patrick Joyce, Chief, Occupational Health Clinics, Washington VAMC, VHA.

POC: (b)(6)

July 13, 2017. Mr. Michael Amaral, Director, El Paso VA Health Care System, will have a brief introductory meeting with Rep. Pearce. He will also discuss staff concerns he has learned of since his appointment as facility Director.

1:00 P.M.; 2432 Rayburn

POC: (b)(6)

July 13, 2017. Dr. Wendy Tenhula, Deputy Chief Consultant for Specialty Mental Health and Dr. Joseph Thornton, Mental Health, North Florida/South Georgia VHS, will brief staff from the offices of Congressmen Al Lawson (FL-05) and John Rutherford (FL-04) on VA mental health initiatives.

2:00 P.M.; 421 Cannon

POC: (b)(6)

July 13, 2017. HVAC Subcommittee on Health will meet in open session to conduct a hearing on VA Clinical Productivity and Efficiency.

2:00 P.M.; 334 Cannon

POC: (b)(6)

July 13, 2017. Dr. Peter Alemenoff, Deputy Executive Director, Clinical Integration, Office of Community Care will meet with SVAC minority staff for a discussion on the SAIL data for Montana.

3:00 P.M.; 825A Hart

POC: (b)(6)

July 13, 2017. VISN 19 leadership will provide a "State of the VISN 19 Network and Medical Centers" briefing to members within the VISN catchment area. Meetings for Thursday include:

Rep. Markwayne Mullin (R-OK-02)

Sen. Mike Lee (R-UT)

Sen. Michael Bennet (D-CO)

Sen. Orrin Hatch (R-UT)

Rep. Chris Stewart (R-UT-02)

Meetings will be held at varying times and locations

POC: (b)(6)

Government Accountability Office (GAO) Activity:

Entrance Conferences

FOR INTERNAL USE ONLY

July 13, 2017. In response to a request from the Chairman of House Veterans Affairs Committee, GAO is beginning its review on ***Healthcare Facilities Operations and Maintenance*** (GAO Code 102114).

GAO's Objectives are to answer the following questions:

- VA's process for planning for operations and maintenance needs at VA medical facilities, including budgeting and cost estimations;
- The effectiveness of VA's oversight of VA medical facilities operations and maintenance needs, at the national and local levels;
- The challenges, if any, VA faces in operation and maintaining medial facilities, and how those challenges are addressed.

11:00 A.M.; VACO, Room 630

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

(Tentative) July 17, 2017. The HVAC full committee is tentatively scheduled to hold a legislative hearing on one draft bill related to GI Bill benefits

Time: TBD Room: TBD

POC: (b)(6)

July 18, 2017. The House Committee on Veterans Affairs Chairman, Rep. Phil Roe, will hold a roundtable discussion on the opioid crisis. The discussion will center on how the opioid crisis is affecting our Veteran population and what are some potential solutions to curbing opioid abuse.

10:00 A.M.; 334 Cannon

POC: (b)(6)

July 18, 2017. HVAC DAMA intends to hold a Roundtable on Disability Examinations.

2:00 P.M.; 334 Cannon

Witnesses: Beth Murphy, Director, Compensation Service, VBA; Mary Glenn, Deputy Director for Contract Exams, Compensation Service, VBA; Patricia Murray, Chief Officer, Office of Disability and Medical Assessment, VHA

POC: (b)(6)

July 19, 2017. SVAC will convene a hearing to consider the pending nominations of Tom Bowman to be Deputy Secretary of the Department of Veterans Affairs, Jim Byrne to be General Counsel of the Department of Veterans Affairs, Brooks Tucker to be Assistant Secretary of Congressional and Legislative Affairs of the Department of Veterans Affairs, and possibly others to be named later.

Witnesses: Tom Bowman, Jim Byrne, Brooks Tucker, and possibly others to be named later

2:30 P.M.; 418 Russell

POC: (b)(6)

July 25, 2017. HVAC Subcommittee on Disability Assistance and Memorial Affairs will hold a hearing on VBA's processing of claims for benefits based on Post-Traumatic Stress Disorder.

FOR INTERNAL USE ONLY

10:30 A.M.; 334 Cannon

Witness: TBD

POC: (b)(6)

TBD. Field Hearing on Access to Care and Care in the Community both in rural areas. The hearing will be held in Duluth, MN, with the full committee. This hearing was at the request of the minority. It is a possibility Chairman Roe will not be in attendance, so another member of the majority will serve as the Chairman. They are requesting Dr. Yehia, someone from the Office of Rural Health, and a local witness (MCD).

Time and Location TBD

POC: (b)(6)

TBD. The HVAC EO Subcommittee will hold a legislative hearing on the agenda set out below.

Agenda

H.R. 43 - To authorize the use of Post-9/11 Educational Assistance to pursue independent study programs.

H.R. 245 - Veterans' Education Equity Act.

H.R. 1104 - Veterans To Enhance Studies Through Accessibility Act.

H.R. 1112 - Shauna Hill Post-9/11 Education Benefits Transferability Act.

H.R. 1216 - Protecting Veterans from School Closures Act of 2017.

H.R. 1331 - Veterans Success on Campus Act of 2017.

H.R. 1384 - Reserve Component Benefits Parity Act.

H.R. 1793 - Veteran Education Priority Enrollment Act of 2017.

H.R. 1956 - To increase the amounts of educational assistance payable under Survivors' and Dependents' Educational Assistance Program of the Department of Veterans Affairs.

H.R. 1989 - Veteran Employment Through Technology Education Courses Act.

H.R. 1994 - Vocational Education and Training Enhancement for Reintegration Assistance Now Act.

H.R. 2099 - GI Bill Fairness Act of 2017 Act.

H.R. 2100 - Work Study for Student Veterans Act.

H.R. 2103 - To include the Frye Scholarship in the Yellow Ribbon GI Education Enhancement Program.

H.R. 2108 - GI Bill STEM Extension Act of 2017.

H.R. 2257 - To consolidate certain eligibility tiers under the Post-9/11 Education Assistance Program of the Department of Veterans Affairs.

Draft Bill - GI Bill Processing Improvement Act.

Draft Bill To provide for an election requirement and reduction in basic pay for members of the Armed Forces entitled to educational assistance under Department of Veterans Affairs Post-9/11 Educational Assistance Program.

Witness: Curtis Coy, Deputy Under Secretary for Economic Opportunity.

10:00 A.M.; 334 Cannon

POC: (b)(6)

Member Engagement Requests for Senior Leaders

Sen/Rep	Last Name	First Name	State	Type of Engagement	Received	Date Scheduled	Topic
---------	-----------	------------	-------	--------------------	----------	----------------	-------

FOR INTERNAL USE ONLY

Sen	Tester	Jon	MT	Travel		8/24/2017	SecVA State Visit Request
Sen	Daines	Steve	MT	Travel		8/24/2017	Ft Harrison, MT
Rep	Bishop	Sanford	GA	Speech		9/22/2017	VA health care system for 2040, specifically for women and minorities
Sen	Rubio	Marco	FL	Meeting	5/4/2017		Accountability Legislation
Sen	Sullivan	Dan	AK	Travel	2/1/2017		SecVA State Visit Request
Sen	Manchin	Joe	WV	Travel	2/1/2017		SecVA State Visit Request
Rep	Esty	Elizabeth	CT	Travel	3/15/2017		Newington & Farmington, CT
Rep	Kuster	Ann McClane	NH	Travel	3/15/2017		Nashua, NH Homelessness/Suicide White River Junction - Opioid
Rep	Bacon	Don	NE	Meeting	3/23/2017		Omaha Ambulatory Care Center
Rep	Moulton	Seth	MA	Meeting	5/10/2017		Priorities
Rep	Arrington	Jodey	TX	Meeting	4/5/2017		VA Priorities – Proactive
Rep	Lieu	Ted	CA	Travel	5/30/2017		West LA
Rep	Gonzales-Colon	Jennifer	PR	Meeting	6/7/2017		Puerto Rico Concerns
Rep	Norcross	Donald	NJ	Meeting	6/8/2017		Constituent
Sen	Tillis/Tester		NC/MT	Meeting	6/20/2017		Choice
Rep	Rooney	Francis	FL	Travel	6/23/2017		
Rep	Davis/Bost	Rodney/Mike	IL	Travel	6/30/2017		Forum

From: (b)(6) /o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)
To:
Cc:
Bcc:
Subject: Morning Report: Monday, March 20, 2017
Date: Fri Mar 17 2017 17:12:35 CDT
Attachments: EAS

All,

Attached is the Morning Report for Monday, March 20, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Monday, March 20, 2017

Hot Issues

*March 16 and 17: House floor action: The House passed the following three bills.

- By a vote of 240-175, H.R. 1181, the Veterans 2nd Amendment Protection Act would prevent the names of Veterans who have been deemed incompetent for VA benefits purposes from being provided to the database used for firearms purchases, unless they have been found by a judicial authority to be a danger to themselves or others. The Administration issued a statement in support of the bill;

- By a vote of 237-178, H.R. 1259, the VA Accountability First Act would establish expedited removal authority for VA employees generally. It also includes measures to recoup relocation expenses and performance awards, allowing direct hiring for VAMC and VISN directors, and reduce benefits for VA employees convicted of certain crime. The Administration issued a statement in support of the bill. Two significant amendments failed which would have narrowed or modified the removal provisions in the bill, and a number of minor or technical changes were adopted by voice vote;

- By a vote of 412-0, H.R. 1367, which has been put forward as an effort to help VA hire and retain VA employees. Among the provisions are measures that would establish a fellowship program to encourage interchange of employees from the private sector, require performance appraisals of political appointees, broaden the application of Veteran's preference in employment, allow speedier hiring of former VA employees, require a central vacancy database, and strengthen training for HR professionals. The bill was modified in a number of respects to reduce the estimated cost of some provisions. A number of other minor or technical amendments were approved by voice vote.

Emerging

- None

Congressional Letters and Meeting Requests Received

- None

Friday, March 17, 2017 Events

- March 17, 2017. Mr. Michael Valentino, Chief Consultant, Pharmacy Benefits Management, briefed Mr. James Cari, Manager, Legislative Policy and Strategy Development for the U.S. Postal Service, and discussed the loss of medications that occur during the shipping process. During the

February 27, 2017, Hearing before HVAC-O&I, Dr. Clancy testified that 91.4 percent of reported drug losses occur in the mail (USPS and UPS).

10:00 A.M.; Teleconference

POC: (b)(6)

Summary: Mr. Valentino and others from Pharmacy Benefits Management (PBM) and the Consolidated Mail-Order Pharmacy Team were on line for VA. Mr. Cari was joined by U.S. Postal Service Investigators and a representative from USPS Office of Government Relations. After the February 27 HVAC-O&I hearing on Drug Diversions, the Committee asked USPS for follow up concerning VA's testimony that 94.1 percent of reported controlled substance losses occur during shipping. USPS requested the call with VA subject matter experts to get more information in order to better understand VA's data. Mr. Valentino explained the context of the hearing and what the data represented. USPS asked for an additional breakdown to include the number/percentage of controlled substances shipped by USPS vs UPS, the number/percentage shipped vs disbursed from a VA pharmacy and the actual amount of losses vs reported losses given that a delayed delivery may initially be reported as a loss as well as the number/percentage of actual losses attributable to USPS. PBM agreed to parse VA data to provide the requested breakouts.

· March 17, 2017. Sean Clark, National Coordinator, Veterans Justice Outreach Program, briefed Representative Coffman's on the Veterans Justice Outreach (VJO) program.

2:00 P.M.; Teleconference

POC: (b)(6)

Summary: Mr. Clark explained VJO Coordinators identify justice-involved Veterans and contact them through outreach, in order to facilitate access to VA services at the earliest possible point by building and maintaining partnerships between VA and key elements of the criminal justice system. The staff expressed concern that the program doesn't have the resources it needs to be fully successful. Mr. Clark conceded that there are resource problems. In closing, the staff said Rep. Coffman is interested in introducing legislation along with Senator Flake to allocate additional resources to the Veterans Justice Outreach Program.

· March 17, 2017. (Continued - March 9, 2017) Rob Thomas, OI&T, Acting Assistant Secretary, briefed SVAC minority staff on "VA's Major IT Projects."

2:00 P.M.; VACO, Room 703

POC: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

· March 17, 2017. Willie Clark, Deputy Under Secretary for Field Operations, VBA and Mike Frueh, Chief of Staff, VBA, briefed SVAC minority staff regarding mandatory overtime.

2:00 P.M.; Teleconference

POC: (b)(6)

Summary: VBA staff provided a friendly update to SVAC minority staff regarding VBA's mandatory overtime effort beginning March 7. SVAC minority seemed to appreciate the information and expressed interest in VBA's assessment of the situation when the current 30-day effort ends in early April.

· March 17, 2017. (Postponed - March 14, 2017). Dr. Neil Evans, Co-Director, Connected Health, VHA briefed the Senate Veterans Affairs Committee on how VA provides mental healthcare to those in rural areas of the country – either through mobile providers or through telemedicine.

3:30 P.M.; VACO 511

POC: (b)(6)

Summary: Dr. Evans explained that Tele-Mental Health of information and telecommunication technologies to deliver mental health services when the provider and the Veteran are separated by geographical distance. The SVAC staff were interested to know about VA's plan for the Tele-Mental Health Hub in South Dakota and if VA had capacity to help treat National Guard soldiers that are in rural areas but not within their deployment window for coverage under Tricare. Dr. Evans responded that the Sioux Falls Telemental Health Hub plans to expand Tele-Mental Health services though implementation of Behavioral Health Interdisciplinary Program (BHIP) teams in the northern and southern CBOC tiers. The congressional staff were also interested in how Congress can help expand VA's Telehealth program. Dr. Galpin explained VA providers delivering Telehealth across State lines from a location not on Federal property, or to a patient not located on Federal property, have no clear protection from the enforcement of State laws that require local licensure. He also mentioned that VA is seeking legislation that allows VA providers to care for Veterans using Telehealth irrespective of the location of the provider or Veterans.

Look Ahead- Monday, March 20, 2017

· March 20, 2017. Dr. Yehia, Deputy Under Secretary for Health for Community Care, will brief SVAC Minority staff along with Sen. Tester's local staff on the Choice Program Scheduling Options for Montana.

10:30 A.M.; Teleconference

POC: (b)(6)

· March 20, 2017. Dr. Baligh Yehia, Assistant Deputy Under Secretary for Health - Community Care will brief members of Senator Steve Daines's staff regarding the Choice Program.

12:30 PM, Teleconference

POC: (b)(6)

· March 20, 2017. Margarita Devlin, Executive Director, Benefits Assistance Service, will brief staff from Congressman Robert Aderholt's (R-AL-04) office on education and training benefits available to

service members upon departing the military.

1:30 P.M.; 235 Cannon

POC: (b)(6)

Government Accountability Office (GAO) Activity:

Entrance Conference

· March 20, 2017. In response to a request by the Chairs of the House Armed Services Committee and the House Veterans' Affairs Committee, GAO is beginning its work on Reverse Auctions (GAO Code 101428).

GAO's key questions:

- What are the trends in use of reverse auctions over the past 5 years?
- What steps have the agencies taken to improve the use of reverse auctions?
- To what extent did agencies achieve benefits through reverse auctions, such as enhanced competition and savings, with consideration of fees paid?

1:00 P.M.; VACO, Room 632

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· March 21, 2017. (Tentative). The HVAC EO Subcommittee has informally notified VA it intends to hold a legislative hearing. The only bill on the agenda at this time concerns "official time" and other labor management and personnel matters. VA witnesses have not been established.

Time: TBD.; Room TBD

POC: (b)(6)

· March 22, 2017. Joint Hearing of the House and Senate Committee's on Veterans' Affairs to

receive the Legislative Presentation of Multiple Veterans Service.

10:00 A.M.; G-50 Dirksen

POC: (b)(6)

· March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans' Affairs, Subcommittee on Health will conduct an oversight hearing on "Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers."

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

· March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

Time 1:30 pm.; Room: Cannon 334

POC: (b)(6)

· March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

Time 8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.
- H.R. 467 - The VA Scheduling Accountability Act.
- H.R. 907 - The Newborn Care Improvement Act.
- H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
- H.R. 1005 - To improve the provision of adult day health care services for Veterans.
- H.R. 1058 - The VA Provider Equity Act.

- H.R. 1162 - The No Hero Left Untreated Act.
- H.R. 1545- VA Prescription Data Accountability Act of 2017
- Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
- Draft Bill - To prohibit smoking in any VHA facility.

· April 5, 2017. (Tentative). The HVAC Disability and Memorial Affairs Subcommittee has informally notified VA it intends to hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

Time TBD; Room TBD

POC: (b)(6)

Tentative Agenda (Couple more bills may come)

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- Draft Bill Beneficial Travel for VBA (authorization fix) will send)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Brownley

Julia

CA

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

O'Rourke

Beto

TX

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bost

Mike

IL

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA

State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA

State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA

State Visit Request

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA

Delaware State Veterans Summit

Sen

McCaskill

Claire

MO

Call

3/21/2017

Arla Harrell Act

Sen

Gillibrand

Kirsten

NY

Call

3/22/2017

Blue Water Navy

Sen

Sanders

Bernie

VT

Meeting

3/23/2017

Privatization, Choice, Drug Costs

(Meeting in Office of Secretary)

Rep

Mast

Brian

FL

Meeting

4/3/2017

Meet & Greet

Sen

Murray

Patty

WA

Call/Meeting

3/8/2017

Caregivers

Rep

Sablan

Gregorio

NMI

Meeting

3/7/2017

Access to Care in the Northern Marianas Islands

Sen

Duckworth

Tammy

IL

Call

3/8/2017

TBD

HVAC Minority Member Retreat

Meeting

(Annapolis)

3/24/2017

SecVA's Way Forward for VA

Rep

McMorris Rogers

Cathy

WA

Meeting

3/24/2017

VA issues and Moving Forward in the 115th

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Sen

Klobuchar

Amy

MN

Call

3/16/2017

Burn Pit Legislation

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Fri Mar 17 17:12:35 CDT 2017

Document ID: 0.7.10678.97940-000001

Attachment Name: EAS

Locator: es:\pst*\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\David.Shulkin.pst:00000000c63b368bb461554d9ed46b1767740f1044c52c00: :0700c4bf280a7ada929b983ad13d785b1f18328293e91abab1e6cb8b933ece24483d

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) </o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Friday, March 17, 2017
Date: Thu Mar 16 2017 16:36:51 CDT
Attachments: EAS

All,

Attached is the Morning Report for Friday, March 17, 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Friday, March 17, 2017

Hot Issues

- None

Emerging

- None

Congressional Letters and Meeting Requests Received

- March 16, 2017. Ranking Member Senator Jon Tester (SVAC), and 17 other Senators expressed concern over sexual harassment reports regarding female service members and Veterans.
 - o Received March 16, 2017: VAIQ #7781860

Thursday March 16, 2017 Events

- March 15, 2017. Barbara Ward, Director, Center for Minority Veterans, briefed

Rep. Sanford Bishop (D-GA-02) on services the Center provides and the advisory committee's most recent recommendations from their 2016 annual report.

4:00 P.M.; 2407 Rayburn

POCs: (b)(6)

Summary: Barbara Ward, opened the dialogue providing background knowledge and statute history of the VA Center for Minority Veterans (CMV) and the Advisory Committee on Minority Veterans (ACMV), of which Rep. Bishop stated he was familiar with due to his years of Congressional Black Caucus-Veterans' Braintrust Committee engagement and commitment. In addition, Ms. Ward highlighted the recently published 2017 Minority Veterans Report, which reflects current and future Minority Veterans' demographics and utilization of VA benefits and services. Ms. Ward also covered the CMV strategic plan and current targeted outreach initiatives. She reviewed the role of the Advisory Committee on Minority Veterans and pointed out specific recommendations within the 2016 ACMV report. Rep. Bishop asked questions regarding the ACMV, especially screening and the selection process of committee members, and support from senior VA leadership. Ms. Ward provided assurance that VA senior leadership is critical to and supportive of the ACMV member selection process and that VA leadership value the recommendations submitted annually by the ACMV. In addition to leadership support of the ACMV, Ms. Ward indicated leadership support for the CMV's targeted outreach efforts. Rep. Bishop asked for specific information regarding challenges identified as a result of the 2016 ACMV Report. In response, Ms. Ward and Mr. Newsome (Deputy Director, CMV) referred to the ACMV's

recommendations with specific attention towards the VA gathering comprehensive demographic (race/ethnicity) data to enhance access to VA benefits and services, and support for the VA Office of Health Equity to identify and address health disparities. Lastly, Rep. Bishop encouraged ensuring that members within the HVAC and Tri-Caucus have access to the 2017 Minority Veterans Report and the 2016 Advisory

Committee on Minority Veterans Report.

· March 16, 2017. Subject Matter Experts from VBA's Pension and Fiduciary Services had a teleconference with SVAC Minority staff to discuss VA's FY17 legislative proposals on fiduciaries.

12:30 P.M.; Teleconference

POC: (b)(6)

Summary: SVAC Minority staff requested information to gather context on fiduciary misuse and the legislative proposals from the VA. Two of the proposals discussed were on the reissuance of VA benefit payments to all victims of misuse and the exemption to the right to the Financial Privacy Act by fiduciaries of VA beneficiaries. Minority staff indicated that the proposal to reissue VA benefit payments of fiduciary misuse was noncontroversial within the Committee. SVAC minority staff appreciated the call and predicted that these issues will likely be brought up in the near future but did not give a

specific timeframe.

· March 16, 2017. Dr. Ron Maurer, Acting Deputy Assistant Secretary for Congressional and Legislative Affairs, met with staff from Congressman Brian Mast's (R-FL) office to discuss the recent engagement at the West Palm Beach VAMC.

2:30P.M.; 2184 Rayburn House Office Building

POC: (b)(6)

Summary: Dr. Maurer and the Congressman's staff discussed the Congressman's visit to the West Palm Beach VAMC on Tuesday.

· March 16, 2017. Bridget McGregor, RN Manager, HCBS, Patient Care Services and Curtis Jordan, VISN 19 Network Contract Manager provided an overview of the current nursing home situation in Montana to the Senate Veterans Affairs Committee and Senator Tester's State Staff.

3:30 P.M.; 825A Hart

POC: (b)(6)

Summary: SVAC staff is concerned with potential access issues to nursing homes for Veterans in Montana and nationwide because local nursing home companies have reported they are not renewing their contracts because they are unsatisfied with the government's payment rates. The staff asked if VA was working with nursing homes via contracts or provider agreements. Mr. Jordan said that he found it problematic that VA did not use provider agreements. The Senate staff thanked him for his response and stated that they would continue to urge VA to use provider agreements more often. Mr. Curtis also explained the Service Contract Act requires general contractors performing services on contracts to pay

service employees in various classes no less than the wage rates and benefits found in the locality which some nursing homes cannot afford. The congressional staff also asked if there are enough contracts in place to meet the demand. Ms. McGregor explained that there are 115 Veterans in nursing homes in Montana across 36 contracts and that there is never a waitlist to gain access to nursing homes. In closing, the congressional staff said the meeting was very helpful and asked that VA provide them with a schedule of contract renewals and a description of what is being done at VA Central Office to track access and availability of nursing homes.

Look Ahead- Friday, March 17, 2017

· March 17, 2017. Mr. Michael Valentino, Chief Consultant, Pharmacy Benefits Management, will speak with Mr. James Cari, Manager, Legislative Policy and Strategy Development for the U.S. Postal Service, to discuss loss of medications that occur during the shipping process. During the February 27, 2017, Hearing before HVAC-O&I, Dr. Clancy testified that 91.4 percent of reported drug losses occur in the mail (USPS and UPS).

10:00 A.M.; Teleconference

POC: (b)(6)

· March 17, 2017. Sean Clark, National Coordinator, Veterans Justice Outreach Program, will brief Representative Coffman's on the Veterans Justice Outreach (VJO) program.

2:00 P.M.; Teleconference

POC: (b)(6)

· March 17, 2017. (Continued - March 9, 2017) Rob Thomas, OI&T, Acting Assistant Secretary, provided a briefing to SVAC minority staff on "VA's Major IT Projects."

2:00 P.M.; VACO, Room 703

POC: (b)(6)

· March 17, 2017. Willie Clark, Deputy Under Secretary for Field Operations, VBA and Mike Frueh, Chief of Staff, VBA, will provide a briefing to SVAC minority staff regarding mandatory overtime.

2:00 P.M.; Teleconference

POC: (b)(6)

· March 17, 2017. (Postponed - March 14, 2017). Dr. Neil Evans, Co-Director, Connected Health, VHA will brief the Senate Veterans Affairs Committee on how VA provides mental healthcare to those in rural areas of the country – either through mobile providers or through telemedicine.

3:30 P.M.; VACO 511

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

· March 21, 2017. (Tentative). The HVAC EO Subcommittee has informally notified VA it intends to hold a legislative hearing. The only bill on the agenda at this time concerns “official time” and other labor management and personnel matters. VA witnesses have not been established.

Time: TBD.; Room TBD

POC: (b)(6)

· March 22, 2017. Joint Hearing of the House and Senate Committee’s on Veterans’ Affairs to receive the Legislative Presentation of Multiple Veterans Service.

10:00 A.M.; G-50 Dirksen

POC: (b)(6)

· March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans’ Affairs, Subcommittee on Health will conduct an oversight hearing on “Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers.”

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

· March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran’s appeals, with a focus on the VAVSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

Time 1:30 pm.; Room: Cannon 334

POC: (b)(6)

· March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by

Susan Blauert, Deputy Chief Counsel.

Time 8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
 - H.R. 95 - The Veterans' Access to Child Care Act.
 - H.R. 467 - The VA Scheduling Accountability Act.
 - H.R. 907 - The Newborn Care Improvement Act.
 - H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
 - H.R. 1005 - To improve the provision of adult day health care services for Veterans.
 - H.R. 1058 - The VA Provider Equity Act.
 - H.R. 1162 - The No Hero Left Untreated Act.
 - Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
 - Draft Bill - To prohibit smoking in any VHA facility.
- April 5, 2017. (Tentative). The HVAC Disability and Memorial Affairs Subcommittee has informally notified VA it intends to hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

Time TBD; Room TBD

POC: (b)(6)

Tentative Agenda (Couple more bills may come)

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- Draft Bill Beneficial Travel for VBA (authorization fix) will send)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Brownley

Julia

CA

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

O'Rourke

Beto

TX

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bost

Mike

IL

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA

State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA

State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA

State Visit Request

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA

Delaware State Veterans Summit

Sen

McCaskill

Claire

MO

Call

3/21/2017

Arla Harrell Act

Sen

Gillibrand

Kirsten

NY

Call

3/22/2017

Blue Water Navy

Sen

Sanders

Bernie

VT

Meeting

3/23/2017

Privatization, Choice, Drug Costs

(Meeting in Office of Secretary)

Rep

Mast

Brian

FL

Meeting

4/3/2017

Meet & Greet

Sen

Murray

Patty

WA

Call/Meeting

3/8/2017

Caregivers

Rep

Sablan

Gregorio

NMI

Meeting

3/7/2017

Access to Care in the Northern Marianas Islands

Sen

Duckworth

Tammy

IL

Call

3/8/2017

TBD

HVAC Minority Member Retreat

Meeting

(Annapolis)

3/24/2017

SecVA's Way Forward for VA

Rep

McMorris Rogers

Cathy

WA

Meeting

3/24/2017

VA issues and Moving Forward in the 115th

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Rep

Esty

Elizabeth

CT

Travel

3/15/2017

Newington & Farmington, CT

Rep

Kuster

Ann McClane

NH

Travel

3/15/2017

Nashua, NH Homelessness/Suicide

Sen

Klobuchar

Amy

MN

Call

3/16/2017

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Thu Mar 16 16:36:51 CDT 2017

Document ID: 0.7.10678.59044-000001

Attachment Name: EAS

Locator: es:\pst*\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\David.Shulkin.pst:00000000c63b368bb461554d9ed46b1767740f1084c52c00: :0700e3a5d359de0d4677b72525d94f6dbf9255f719ac84e30c6a00cd15caf0a167b7

Reason: : This file is empty (i.e., its length is zero bytes)

From: (b)(6) </o=va/ou=vba
philadelphia/cn=recipients/cn=(b)(6)>
To:
Cc:
Bcc:
Subject: Morning Report: Thursday, March 16, 2017
Date: Wed Mar 15 2017 16:44:53 CDT
Attachments: EAS

All,

Attached is the Morning Report for Thursday, March 16 , 2017. This document is for internal use only.

Thank you kindly,

(b)(6)

Department of Veterans Affairs

Health Program Analyst, Office of Congressional and Legislative Affairs

810 Vermont Ave NW

Washington, DC 20420

Phone: (b)(6)

Secretary's Morning Report

Prepared by the Office of Congressional & Legislative Affairs

Thursday, March 16, 2017

Hot Issues

- House floor action expected Thursday, March 16 or Friday, March 17: The House is scheduled to take up the following bills, subject to a process to be established by the House Rules Committee. None of the bills has been the subject of a hearing in the 115th Congress:

H.R. 1181, the Veterans 2nd Amendment Protection Act would prevent the names of Veterans who have been deemed incompetent for VA benefits purposes from being provided to the database used for firearms purchases, unless they have been found by a judicial authority to be a danger to themselves or others;

H.R. 1259, the VA Accountability First Act would establish expedited removal authority for VA employees generally. It also includes measures to recoup relocation expenses and performance awards, allowing direct hiring for VAMC and VISN directors, and reduce benefits for VA employees convicted of certain crimes; and,

H.R. 1367, which has been put forward as an effort to help VA hire and retain VA employees. Among the provisions are measures that would establish a fellowship program to encourage interchange of employees from the private sector, require performance appraisals of political appointees, broaden the application of Veteran's preference in employment, allow speedier hiring of former VA employees, require a central vacancy database, and strengthen training for HR professionals.

Emerging

- None

Congressional Letters and Meeting Requests Received

- March 2, 2017. Chairman David P. Roe (HVAC) requested information in reference to a case at the VA Caribbean Healthcare System.

- o Received March 15, 2017: VAIQ #7781579

- March 13, 2017. Sen. Tammy Baldwin (D-WI) expressed concern about the Choice Program in Wisconsin.

- o Received March 13, 2017: VAIQ #7781469

- March 13, 2017. 10 Members of Congress expressed concern in reference to the GAO, High Risk Series.

- o Received March 13, 2017: VAIQ #7781330

- March 15, 2017. Sen. John Boozman (R-AR) and Rep. French Hill (R-AR) requested VA's plan to resolve the solar panel project at the John L. McClellan Memorial Veterans Hospital in Little Rock, Arkansas.

- o Received March 15, 2017: VAIQ #7781465

Wednesday March 15, 2017 Events

- March 15, 2017. Thomas F. Klobucar, PhD, Acting Director, Office of Rural Health, briefed a Rural Health Care update to the staff of Congressman Tim Walz.

10:00 A.M.; Teleconference

POC: (b)(6)

Summary: Dr. Klobucar walked the Representative Walz's staff through a VA Office of Rural Health 101 brief, highlighting: the office's history, including statute which authorized the establishment of the program as well as recognition of the rural health resource centers; current and impending challenges Vets in rural locations face (#1 is provider and specialist shortages); current rural health initiatives and projections; and rural health solutions within MyVA access initiative. The briefing was well received by the Congressman's office. As VA looks to the future of VA, particularly within the care in the community realm, the Congressman's staff asked that the Office of Rural Health play a major role in those discussions.

- March 15, 2017. Senate Veterans' Affairs Committee held a hearing on Government Accountability Office's (GAO) High Risk List.

Witness: Dr. Carolyn Clancy, Under Secretary for Health for Organizational Excellence

2:30 P.M.; 418 Russell

POC: (b)(6)

Summary: At the opening of the hearing GAO criticized VA for not acting on their recommendations with a sense of urgency. During her opening remarks, Dr. Clancy countered that VA takes GAO's work seriously and appreciates the advice and feedback VA has received from GAO. VAOIG in their

testimony called attention to a few examples of programs that have been vulnerable to waste, fraud, and abuse. Senator Tester was specifically concerned with an OIG report which assessed the extent that patients experienced delays and the impact of any delays on patient outcomes at the VA Montana Health Care System (system), Fort Harrison, MT. Dr. Clancy acknowledged the Senator's concern and not only explained the ways in which the facility is addressing issues, but also explained how the facility was reviewing the root causes of the original issues. Senator Tester expressed satisfaction with the new VA leadership in Montana. A topic of concern for Senator Tillis was the OIG's Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6. Dr. Clancy discussed some of the initiatives implemented within VA since the timeframe of the OIG report. Overall, the duration of the hearing was short and the discussion was not contentious.

- March 15, 2017. Barbara Ward, Director, Center for Minority Veterans, briefed

Rep. Sanford Bishop (D-GA-02) on services the Center provides and the advisory committee's most recent recommendations from their 2016 annual report.

4:00 P.M.; 2407 Rayburn

POCs: (b)(6)

Summary: Due to the timing of the event, a summary will be provided in tomorrow's report.

Look Ahead- Thursday, March 16, 2017

- March 16, 2017. Dr. Neil Evans, Co-Director, Connected Health, VHA will brief the Senate Veterans Affairs Committee on how VA provides mental healthcare to those in rural areas of the country – either through mobile providers or through telemedicine.

3:30 P.M.; Teleconference

POC: (b)(6)

Upcoming Hearings and Testimony Due to Congress

- March 21, 2017. (Tentative). The HVAC EO Subcommittee has informally notified VA it intends to hold a legislative hearing. The only bill on the agenda at this time concerns "official time" and other labor management and personnel matters. VA witnesses have not been established.

Time: TBD.; Room TBD

POC: (b)(6)

- March 22, 2017. Joint Hearing of the House and Senate Committee's on Veterans' Affairs to receive the Legislative Presentation of Multiple Veterans Service.

10:00 A.M.; G-50 Dirksen

POC: (b)(6)

· March 22, 2017. (Postponed – March 16, 2017). The House Committee on Veterans' Affairs, Subcommittee on Health will conduct an oversight hearing on "Healthy Hiring: Enabling VA to Recruit and Retain Quality Providers."

Witnesses: Mr. Steve Young, Deputy Under Secretary for Health for Operations and Management and Dr. Paula Molloy, Assistant Deputy Under Secretary for Health for Workforce Services.

2:00 P.M.; 334 Cannon

POC: (b)(6)

· March 28, 2017. The HVAC DAMA Subcommittee will hold a roundtable discussion on the topic of Veteran's appeals, with a focus on the VA/VSO appeals modernization proposal. The Subcommittee requested a VBA and a BVA representative participate in the discussion – those participants have not been established.

Time 1:30 pm.; Room: Cannon 334

POC: (b)(6)

· March 29, 2017. The HVAC Health Subcommittee will hold a legislative hearing on the agenda set out below. VA witness will be Dr. Jennifer Lee, DUSH for Policy and Services accompanied by Susan Blauert, Deputy Chief Counsel.

Time 8:00 A.M.; 334 Cannon

POC: (b)(6)

- H.R. 91 - The Building Supportive Networks for Women Veterans Act.
- H.R. 95 - The Veterans' Access to Child Care Act.
- H.R. 467 - The VA Scheduling Accountability Act.
- H.R. 907 - The Newborn Care Improvement Act.
- H. R. 918 - The Veteran Urgent Access to Mental Healthcare Act.
- H.R. 1005 - To improve the provision of adult day health care services for Veterans.
- H.R. 1058 - The VA Provider Equity Act.
- H.R. 1162 - The No Hero Left Untreated Act.

- Draft Bill - The Veterans Affairs Medical Scribe Pilot Act of 2017.
- Draft Bill - To prohibit smoking in any VHA facility.

· April 5, 2017. (Tentative). The HVAC Disability and Memorial Affairs Subcommittee has informally notified VA it intends to hold a legislative hearing on the agenda set out below. VA witnesses have not been established.

Time TBD; Room TBD

POC: (b)(6)

Tentative Agenda (Couple more bills may come)

- HR 1328 (Bost)-Auto COLA
- HR 1329 (Bost)-Annual COLA
- HR 1390 (Banks)-Transportation to State and Tribal Cemeteries
- Draft Bill Beneficial Travel for VBA (authorization fix) will send)
- HR 105 (Brownley)-Repayment of Misused Benefits of Veterans with Fiduciaries
- Draft Bill (Walz) Quicker Veterans Benefits Delivery Act
- HR 299 (Valadao) Blue Water Navy

Member Engagement Requests for Senior Leaders

Sen/Rep

Last Name

First Name

State

Type of Engagement

Received

Date Scheduled

Topic

Rep

Brownley

Julia

CA

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

O'Rourke

Beto

TX

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bergman

Jack

MI

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Rep

Bost

Mike

IL

Meeting

3/15/2017

VA Priorities

To Be Rescheduled from 3/15

Sen

Sullivan

Dan

AK

Travel

2/1/2017

SecVA

State Visit Request

Sen

Tester

Jon

MT

Travel

2/1/2017

SecVA

State Visit Request

Sen

Manchin

Joe

WV

Travel

2/1/2017

SecVA

State Visit Request

Sen

Carper

Tom

DE

Travel

4/3/2017

SecVA

Delaware State Veterans Summit

Sen

McCaskill

Claire

MO

Call

3/21/2017

Arla Harrell Act

Sen

Gillibrand

Kirsten

NY

Call

3/22/2017

Blue Water Navy

Sen

Sanders

Bernie

VT

Meeting

3/23/2017

Privatization, Choice, Drug Costs

(Meeting in Office of Secretary)

Rep

Mast

Brian

FL

Meeting

4/3/2017

Meet & Greet

Sen

Murray

Patty

WA

Call/Meeting

3/8/2017

Caregivers

Rep

Sablan

Gregorio

NMI

Meeting

3/7/2017

Access to Care in the Northern Marianas Islands

Sen

Duckworth

Tammy

IL

Call

3/8/2017

TBD

HVAC Minority Member Retreat

Meeting

(Annapolis)

3/24/2017

SecVA's Way Forward for VA

Rep

McMorris Rogers

Cathy

WA

Meeting

3/24/2017

VA issues and Moving Forward in the 115th

Rep

Arrington

Jodey

TX

Meeting

3/14/2017

VA Priorities – Proactive

Sen

Daines

Steve

MT

Travel

1/25/2017

Ft Harrison

Owner: (b)(6) (b)(6) </o=va/ou=vba philadelphia/cn=recipients/cn=(b)(6)
Filename: EAS
Last Modified: Wed Mar 15 16:44:53 CDT 2017

Document ID: 0.7.10678.58188-000001

Attachment Name: EAS

Locator: es:\pst*\vaausdcscw201\MS\Collections\GCLAWS 97074 VoteVets Action Fund v. VA\Batch 1 Online\David Shulkin\David.Shulkin.pst:00000000c63b368bb461554d9ed46b1767740f10e4c52c00: :07002a8f152c0f11450de51401c4202ea02e0f1a6b652e787e91d9a507c70e5f3dca

Reason: : This file is empty (i.e., its length is zero bytes)